THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 51 • NUMBER 12
MONTREAL

Highlight for
DECEMBER 1955

RESEARCH IN NURSING

•

THE PLAY ROOM
(See Page 949)

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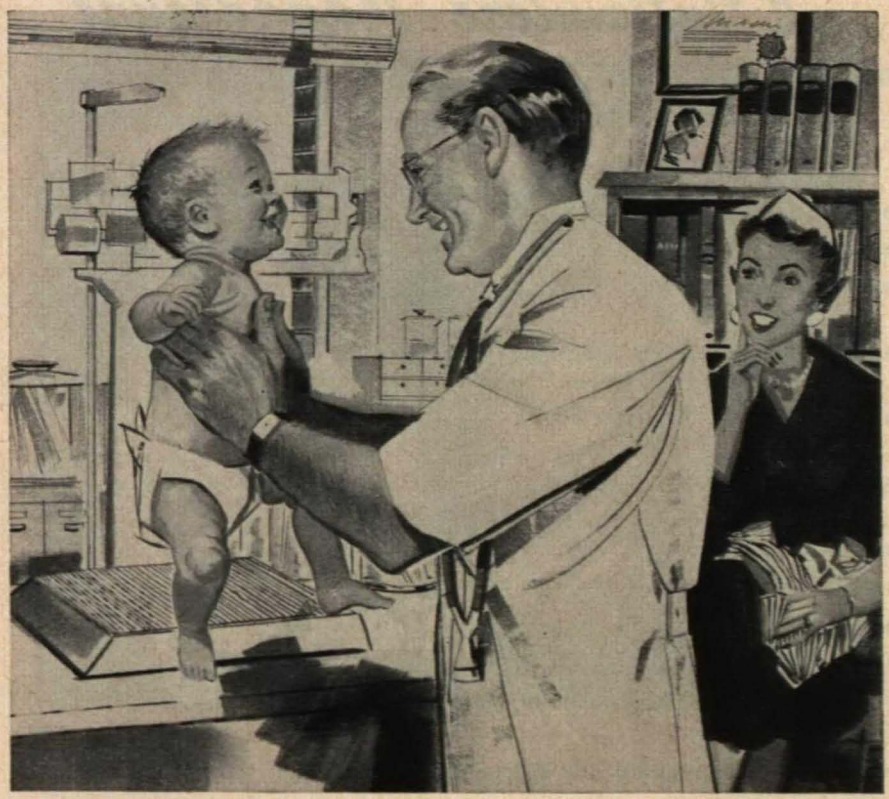

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**: 171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

Between Ourselves

Here we are at the end of another year. Before we close Volume 51 it may be of interest to take a quick glance back to see what this year has meant to nursing and to *The Canadian Nurse*. What have been the highlights, what the biggest worries during these twelve months?

Staffing problems in hospital and public health agencies seem to have been more severe, if the number of pages devoted to "Positions Vacant" is an indicator. Seven and a half pages more, up to the end of November! We are still in the lean years so far as student nurse recruitment is concerned, too. Schools that have had to turn away applicants before are "scraping the bottom of the barrel" as one director put it. It will be another few years yet before the supply catches up with the demand. We are thankful for the way the married nurses are continuing to divide their time between their homes and the professional demands.

Staff changes have beset the Journal office, too. In the clerical field there are shortages. Our work has been considerably brightened by the addition of a new assistant editor in July.

While we did not rise to the excitement of an anniversary dinner to celebrate the Golden Jubilee of *The Canadian Nurse*, the **special issue of March, 1955,** is a proud record of half a century of nursing development. Copies of this anniversary issue are still available for those who did not secure one. The price is 50 cents.

The **Cumulative Index** was available for distribution by May of this year. One of the surprising and, to a degree, disturbing factors that has emerged from the distribution of this index has been the revelation of how many of the Canadian schools of nursing did not order copies of this complete listing of *Journal* articles for the past five years. Is it because they do not bind the back issues, do not keep them or what? We have been able to supply back issues for a number of institutions to complete their files. Copies of the Cumulative Index may be purchased for $2.50.

* * *

Several subscribers have written in for the mailing address of **J. P. Whettenhall** who contributed the excellent article on a pension plan for nurses, published in our September issue. Others may wish to have it, too, so here it is: Mr. J. P. Whettenhall, "Rosehill" Park Road, Banstead, Surrey, England.

* * *

Nurses have a very important role to play in the **formation of good food habits.** We have all known this vaguely but *The American Journal of Nursing* did some investigating to substantiate the belief.

In the responses received from public health organizations over 97 per cent reported that advice on food matters is constantly being sought. The school nursing groups stated that their major problem is in connection with proper breakfasts for school children. Those engaged in occupational health work reported constant inquiries for food information by employees.

In line with the demand for information it is increasingly important that every nurse should have authentic information at her finger-tips. We are still faced with serious problems of malnutrition among infants, children and adults. An unparalleled source of information on all matters relating to nutrition is the Nutrition Division of the Department of National Health and Welfare at Ottawa. At a conference sponsored by the division last summer it was revealed that there is much overlapping in some types of educational and informational materials and yet there is a scarcity of good materials for other purposes. It was unanimously agreed that Canada's Food Rules should be the basis for all nutrition teaching in our country. However, flexibility must be exercised in putting the rules into practice. Choosing a variety of basic foods is now considered to be the key factor in securing a nutritionally balanced diet.

Speaking of nutrition, it won't be many days now before we begin to tuck away all the extra goodies that appear at Christmas time. We hope you have enough pieces of Christmas cake to insure yourself twelve happy months next year. From all of us at the *Journal* offices to all of our subscribers — a very Happy Christmas, good health and prosperity in 1956.

As far as housework is concerned, some women like to do nothing better.

1955 INDEX

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New Products

Edited by DEAN F. N. HUGHES

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Description—Each sugar-coated tablet contains: Reserpine 0.25 mg., rutin N.F. 20 mg., ascorbic acid 30 mg., theophylline 100 mg.

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Administration—One to two tablets, two or three times daily.

AUREOMYCIN SF CAPSULES

Manufacturer—Lederle Laboratories Division, North American Cyanamid Limited, Montreal.

Description—Each cherry-red capsule contains: Chlortetracycline HCl 250 mg., ascorbic acid (C) 75 mg., thiamine mononitrate (B_1) 2.5 mg., riboflavin (B_2) 2.5 mg., niacinamide 25 mg., folic acid 0.375, pyridoxine HCl (B_6) 0.5 mg., calcium pantothenate 5.0 mg., vitamin K (menadione) 0.5 mg., vitamin B_{12} 1 mcgm., as present in concentrated extractives from streptomyces fermentation.

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Description—Each scored green tablet or 5 cc. of elixir represents: Butisol sodium (sodium 5-ethyl-5-sec-butyl barbiturate) 10 mg., ext. belladonna 15 mg.

Indications—As antispasmodic-sedative in such conditions as: irritable colon, pyloroduodenal irritability, peptic ulcer, diarrhea due to acute gastroenteritis, functional dysmenorrhea, etc.

Administration—1 tablet or 1 teaspoonful 3 times daily a half-hour before meals, and 1 or 2 tablets or teaspoonfuls at bedtime.

CORTIMENT DERMAL

Manufacturer—Nordic Biochemicals Ltd., Montreal; *Dist.:* Anglo Canadian Drug Co., Oshawa, Ont., and The Stevens Companies, Winnipeg, Calgary, Vancouver.

Description—A topical solution of hydrocortisone. Each cc. contains 5 mg. in a solution of polyethylene glycol and propylene glycol.

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Administration—Apply a thin, even film over the affected area, allow to dry before replacing clothing. Use initially 3 or 4 times a day, decreasing as relief is obtained.

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Description—Contains per tablet: Salicylamide (5 gr.) 325 mg., ascorbic acid 20 mg.

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Indications—For treatment of cough in acute head and chest colds, laryngitis, acute bronchitis and tracheitis. Indicated for cough attending cardiac disease, spasmodic bronchial cough without dyspnea in children as a manifestation of allergy, whooping cough, influenza and pulmonary tuberculosis.

Administration—Adults: 1 to 2 teaspoonfuls every 2 to 3 hours as necessary. Children: ½ to 1 teaspoonful according to age, 3 or more times daily. Contraindications: Caution is suggested in advanced cardiovascular disease on the basis of the desoxyephedrine.

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Administration—Lotion should be applied to the hair at bedtime and allowed to remain over night. Its application should be preceded by a shampoo if the hair and scalp are oily or greasy. Initially treatment should be repeated eight to ten times. Thereafter, application should be repeated once or twice weekly, or every other week, depending upon severity of condition, to prevent recurrence.

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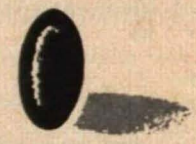

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 51 NUMBER 12

MONTREAL, DECEMBER, 1955

More than Tolerance

THE SEASON when the spirit of good will and friendliness abounds is here again. Watch any crowd milling along the street, any queue lined up for a bus, any purchaser awaiting a turn before piled shop counters. There is a greater buoyancy in the step, more friendly chatter, and a greater willingness to await our turn instead of pushing and shoving. Because it is nearly Christmas we are all a bit more tolerant than usual, a bit more willing, a bit more friendly.

What a pity that this spirit lasts so short a time! We could all do with a lot more tolerance all the year through. Someone has written "We may not be able to love everybody but we can tolerate them." Yet, even as we read that sentence we as nurses should, and many of us do realize that tolerance tends to be cold, impersonal and inactive. It brings no warmth to human relations. It was love, not merely tolerance that He, Whose birth we join in celebrating this month, called for from those who would follow Him in a life of service to humanity.

Nurses do not require a definition of love. From infancy they have been surrounded by it. The bright young things who throng to our schools of nursing have echoed the popular songs that eulogize it ever since they reached their teens. Love is wonderful — ecstatic — eternal! But! Where, in their curriculum, are student nurses reminded of the practical application of love, of good human relations in so far as their patients are concerned?

After fruitlessly hunting through several well known texts on ethics in nursing, psychology, sociology, we asked some school of nursing instructors that question. One suggested it might — might, mind you — be fitted into nursing ethics. Another thought it properly belonged in a course in sociology. Neither could remember it being specifically discussed in their training.

The application of the Golden Rule is the first step in establishing good human relations — "Whatsoever ye would that men should do to you, do ye even so to them." What else? We must have *kindliness* — the genuine kind that stirs our interest in those we serve. We must have *patience* — with eccentrics, with demanders, with surly folk who so often use this mannerism to cover their fear. We must

have *compassion* for those in distress, for those who grieve. All of these add up to much more than tolerance.

If, in our everyday jobs, we add these qualities to tolerance we can imbue our daily work every day of the year with the cherished goodwill associated with Christmas. May the spirit of this happy season be the hallmark of Canadian nurses.

A Happy Christmas to All.

Goodnight old year

Goodnight, Old Year!
Farewell, good friend and teacher.
I stand here on the threshold
of tomorrow
Wiser for what
you have taught me,
Stronger because of problems
you have forced me to solve,
More patient because of errors
you have made me rectify;
My vision clearer because of
things you have shown me,
More tolerant because I have
known temptation and trial,
Happier because I have known
success and triumph
in a measure,
More humble because I also
have known heartbreak;
Hopeful that the future will
bring something of victory
Because the past has brought
something of understanding;
Old Year . . . wise teacher, counselor
guide and friend . . .
Thank you and good night.

A. Paul Hoheisel

Test Questions for Faulty Hearing

Try the following test questions if you feel that your hearing is getting worse, but you are not sure whether it's bad enough to require medical attention.

Do you hear better in noisy places than in quiet ones? Do harsh, loud noises seem painful? Do you seem to hear better with one ear rather than with the other? Do you find that most persons seem to be mumbling when they talk to you? Do you suffer from ringing in the ears? If the answer to more than one of these questions is "yes," the expert who devised these questions advises that it would be wise to see your doctor.—(ISPS)

Doing easily what others find difficult is talent; doing what is impossible for talent is genius.

—Henri-Frédéric Amiel

Surgery in Coronary Artery Insufficiency

ARTHUR VINEBERG, M.D.

THE LIFE OF MAN is in his heart; without it there is no life. This fact has been forced upon the consciousness of the public recently by the ever increasing death rate from heart disease.

In previous articles diseases of the heart caused by congenital or acquired valvular lesions have been discussed. These diseases account for approximately one-third of heart deaths whereas coronary artery disease is responsible for the other two-thirds. Recent reports have placed the mortality rate from coronary artery disease at over 350,000 deaths per year in the U.S.A. Coronary artery disease is now responsible for more deaths annually than cancer or traffic accidents. These figures pertain only to those in whom the finality of death has closed the last chapter of life and with whom medical treatment has failed. Actually, the number of persons who suffer from coronary artery insufficiency must be very great.

This is particularly true if one considers that 80 per cent of all persons suffering from coronary artery occlusion with thrombosis survive the first attack. Unfortunately for the majority their days appear to be numbered. According to published figures, compiled from large groups of patients, 54 per cent survive five years and roughly 18 per cent are alive after ten years. What is still more disturbing is that of those that survive only approximately one-third do so without symptoms and are able to perform their accustomed daily activities.

THE NATURE OF CORONARY ARTERY DISEASE

The contractile power of heart muscle is the effective force that propels blood from the ventricles into the greater and lesser circulations. This muscle is nourished by blood carried to it by three coronary arteries, namely, the right coronary artery, the anterior descending and the circumflex vessels. Each artery sends branches from the surface of the heart into the myocardium to supply three major arteriolar zones. In the normal heart these arteriolar zones are distinct and have no intercommunication. Anoxia caused by slow narrowing of one major vessel stimulates the formation of interzonal communication called collateral circulation. Blood entering one arteriolar zone under such circumstances can flow into all arteriolar myocardial channels. The gradual narrowing of one major artery, therefore, may not be felt by the patient providing one of its good neighbor arteries is capable of sending blood through collateral channels to supply oxygenated blood to the ischemic myocardium. If this process of coronary artery occlusion occurs slowly, and if there is at least one major vessel open, there may be no death of heart muscle and the patient may be asymptomatic.

Unfortunately, in many people the process of arteriosclerosis involves all three major arteries at the same time. Generally, the disease is confined to the surface or epicardial portions of the coronary arteries. This leaves a vast network of arterioles, lying within the heart muscle, that are free of disease. Under such circumstances it is impossible for a neighboring vessel to send fresh blood to an arteriolar zone due to the widespread nature of coronary artery occlusion.

The heart muscle therefore, dies, that is, a myocardial infarction occurs as a result of coronary artery occlusion. The amount of muscle that dies

---

This is the fourth and the last of a series of articles on cardiac surgery written by Dr. Vineberg, who is associated with the Royal Victoria and the Jewish General Hospitals, Montreal.

and is replaced by scar tissue is dependent upon the size of vessels occluded and the ability of the good neighbor arteries to send fresh, oxygenated blood into the stricken area.

Sometimes a sudden coronary artery occlusion results in ventricular filbrillation and immediate death of the patient. If the heart's rhythm is not disturbed by the infarction there is a good chance of survival. It must be remembered that survival after coronary artery occlusion means survival with fewer myocardial fibres to drive the heart pump because myocardial fibres do not regenerate. Each person starts life with a given number of these contracting units with a power for work far in excess of the requirements of daily living. These myocardial reserves are called upon from time to time during life. Perhaps the best example is a comparison between the number of foot-pounds of work a heart performs in driving a 220-pound man 100 yards in 10 seconds and the energy required when that same individual is at rest.

Repeated coronary artery occlusions with infarction steadily whittle down this great reserve of myocardial fibre to a point where the very act of living becomes burdensome. Such patients suffer anginal pain at rest and some develop left ventricular failure.

The presence of angina decubitus, that is, pain at rest without exciting cause and with or without left ventricular failure, indicate that there is very little myocardial reserve left. It is doubtful if any form of treatment can be of much value in such patients.

The problem, as it exists to-day, resolves itself into these three phases:

1. Medical treatment of coronary artery — frequently ineffective and palliative only.
2. Continued research into the causes of arteriosclerosis and its prevention, with the hope that this disease will in the future be prevented or arrested in its early stages of development.
3. Surgical revascularization of the myocardium.

Factually, coronary artery disease presents a mechanical blockade which theoretically can be relieved by mechanical means. Since the coronary vessels become narrowed or blocked close to their origin the points of blockade can be bypassed so that fresh blood can be poured into the relatively healthy arteriolar zones beyond.

Many methods of accomplishing this have been described. Three of these are now being used in the treatment of human coronary artery insufficiency.

Asbestos Powder

Asbestos powder and partial ligation of the coronary sinus: In this operation devised by Claude Beck, asbestos powder is spread around the pericardial sac after partial ligation of the coronary sinus. This partial ligation dams back part of the venous return flow of the left ventricle thereby, it is said by Dr. Beck, opening up collateral vessels between arteriolar zones. The asbestos powder acts as an irritating substance stimulating the formation of hundreds of small capillaries between the parietal and visceral pericardium. The parietal or outer coat of pericardium is well supplied with blood which theoretically could enter the myocardium through the small capillaries in the granulation tissue which forms between the two layers of the pericardium.

Talc Operation

In this operation, devised by Alcott Thompson, of New York, talc is placed within the pericardial sac where it sets up granulomata between the two pericardial layers. In this way Thompson hopes that oxygenated blood will flow from the parietal pericardium into the ventricular myocardium through granulomatous capillary vessels.

Internal Mammary Artery Implantation

In the operation devised by the author, the left internal mammary artery is freed from the chest wall and divided. Its proximal end is buried in the left ventricular muscle. There it quickly sends out branches which join up with the arterioles lying within the myocardium. In this way arterial blood is poured in large quantities from the

internal mammary into the myocardial arteriolar system beyond the points of coronary artery obstructions. Since the internal mammary artery is large it is theoretically possible for it to supply as much blood to the heart muscle as a normal coronary artery. By this procedure the mechanical blockage of coronary vessels by disease is bypassed.

Selection of Patients

We believe that the selection of patients with coronary artery disease for revascularization surgery, no matter which procedure is used, must be based upon sound pathological, physiological and experimental facts.

Indications for Surgery

Primarily, all patients must have anginal pain and be able to walk at least 14 steps. There are two groups of patients:

1. Progressive disease: Such patients give a history of one or more infarctions with a steady decrease in exercise tolerance and an increase in frequency of anginal seizures. Their disease is progressing.

2. Stationary disease: The patients in this group suffer from anginal pain as in the first group and, like them, may be totally or partially disabled. Their disease, however, is stationary showing neither progression nor retrogression.

Both classes of patients need revascularization surgery to increase the blood supply to their oxygen starved heart muscles.

Contraindications

1. Angina Decubitus: When this state has been reached the risk of operation is too great for the probable benefits to be derived. Pain signals originating in a heart working under rest conditions clearly indicate that its functional reserve has been so reduced that it has difficulty pumping the blood necessary for daily living at rest. Without some myocardial reserve it is not logical to expect such a heart to face the added burden imposed upon it by anesthesia and surgery.

2. Failing left ventricle: The presence of left ventricular failure with dilatation indicates that the myocardial muscle has either lost its tone or been replaced by scar tissue. When failure occurs during an attack of infarction and there is recovery, such patients have been accepted for surgery. However, when left ventricular failure is chronic our experience has been that the damage to heart muscle is irreversible. The patient has come too late for help from surgical revascularization.

3. Active disease: Recent coronary artery thrombosis with or without infarction is a definite contraindication to revascularization surgery of any type. A healing stabilization period of at least six months is advisable. Activity must be suspected when there is elevation of the sedimentation rate with changes in the electrocardiogram.

4. Associated diseases: Malignant hypertension, severe diabetes, blood dyscrasias, etc., if not curable, form a definite contraindication. Associated diseases, such as, biliary tract conditions, peptic ulcer, should be treated first.

Results of Surgical Treatment

In properly selected cases the mortality rate following revascularization surgery of any type is under 6 per cent. There is evidence, in the series reported by Beck, Thompson, and the author, that there is prolongation of life expectancy as compared with the mortality rate of medically treated patients.

Mortality and longevity figures are difficult to evaluate and may be misleading. However, the return to work of a totally disabled patient after surgery forms a good individual control. In our own series of 50 internal mammary implants, in those patients without angina at rest, 78 per cent were disabled, not working and unable to walk more than a few blocks or as little as 11 to 30 steps without pain. Seventy-seven per cent of this group has been returned to work, pain free or with less pain. Eighty-four per cent of these patients had had one or more infarctions.

When a totally disabled patient is returned to work and full activity after

revascularization surgery there can be little doubt that the revascularization procedure has helped.

Charles Adams was a case of angina decubitus, taking 300 nitroglycerine tablets per week. At the time of the internal mammary implant at the Royal Victoria Hospital, Montreal, in November 1953, this patient was totally disabled. Four months after operation, he returned to work, pain free. In May 1955 cancer of the pancreas killed this patient suddenly through intestinal obstruction. Serial section through the implanted internal mammary artery showed it to be widely patent and branching out into the myocardium, 18 months after surgery.

It is logical to assume that revascularization surgery helped this patient. Similar reports of other types of operations would indicate that a patient with coronary artery insufficiency has at least a 70 per cent chance of being well after surgery with approximately a 6 per cent chance of not surviving the operation.

In conclusion it now appears that surgical revascularization of the myocardium offers a new hope of stemming the high mortality and morbidity of coronary artery disease as compared with medically treated cases.

Toward Effective Speech

An idea became a reality recently when the Canadian Nurses' Association sponsored a course in public speaking and human relations. Our profession brings us into constant contact with people, either in hospital or in public life. The profession as a whole is judged by the actions of the individual members. We seldom take time to consider that the use — or misuse — of our voices in everyday activities or in public speaking affects others happily or otherwise.

The institute was under the capable direction of Jan Chamberlain. Mrs. Chamberlain obtained her voice training in New York and is the Canadian representatives of the Hesse method. Her studio of Effective Speech in Toronto is known to many. Those attending the sessions represented many of the key positions in nursing and allied services in eastern Canada. There was a total registration of 26 members.

The conference was unique. It was held in the Nursing Education building of the Ottawa Civic Hospital — a distinctive location. Ordinarily a course in effective speech would require weeks of study. In this instance it was condensed into a period of one week. Finally, the members of the group all had had similar professional preparation — something not encountered in the usual class for voice training. The high degree of success attained during the institute can only be attributed to the careful planning and competence of its director. Instruction was given in the proper use of the voice; preparation of public addresses; platform appearance; the technique of introducing and thanking a guest speaker, of proposing and replying to a toast; the method of conducting panel discussions. Each member of the group participated in active practice of the principles which were learned from day to day. Through the courtesy of the C.B.C. an opportunity was given to learn of the proper use of the microphone and a few of the secrets of broadcasting.

The members of the institute were guests of the staff of National Office at a tea during the week. Other social events included a visit to the Health Unit of the Dominion Bureau of Statistics building, a tour of the Nursing Education building, and a coffee party as guests of Miss Young and the teaching staff of the Civic Hospital.

The final session was attended by Miss P. Stiver. She extended thanks from National Office to Mrs. Chamberlain. Miss Marjorie Russell expressed the gratitude of the members of the conference for a week well-spent.

JEAN E. MACGREGOR

When the rich assemble to concern themselves with the business of the poor it is called charity. When the poor assemble to concern themselves with the business of the rich it is called anarchy.

— PAUL RICHARD

The Meaning and Importance of Research in Nursing

HELEN L. BUNGE

RESEARCH HAS A MEANING for nurses just as it does, but in a different way, for the research worker in a well-equipped laboratory — the kind of person so often pictured in magazine articles about research. Let us explore several questions concerning research in nursing; What is research? Why is research in nursing essential? What are some of the needed areas of investigation in nursing? How can we forward research in nursing?

People as a whole, and that includes nurses, have a respect for "research" but they tend to shy away from the word. The term "research" stirs up conflicting feelings within them. Although nurses are grateful for the advances in patient care that have come through research — for example, new drugs, better nursing procedures, more adequate diagnostic measures — the term makes them think of mathematical formulas, statistics, calculating machines, theories, exhaustive library study, and techniques and tools that mean little to them and seem pretty far removed from their daily lives.

Let us define the term "research' as "the systematic investigation of problems." When you investigate a problem in a systematic, thoroughgoing fashion, arriving at a solution to the problem after a consideration of all of the facts that can be collected about it, you are using research methods.

It is not important for our purposes to elaborate on the various and conflicting viewpoints on what research is, although we recognize that there are differences of opinion about the kind of studies to which the term should be applied. The scientific method or the research process actually means:

1) Identifying the problem to be tackled and stating it as exactly as possible.

2) Collecting all the facts that have a bearing on the problem.

3) Studying the facts and seeing what meaning they have for the solution of the problem.

4) Arriving at a solution of the problem or a plan of action in the light of the facts and their interpretation.

5) Trying out the plan of action to see if it is workable.

6) Modifying the plan of action on the basis of try-out, in order to strengthen it.

7) Reporting the study in such form that others may profit.

Let us take a specific example to see how these steps might be actually applied. A head nurse on a hospital ward may be concerned that so much of the graduate nurse time is spent away from the patient. Knowing that there are all too few graduate nurses, she believes that their services should be directed as much as possible to the actual nursing care of patients. Her problem is a hard one to think through and state, but she finally expresses the problem in the form of the following question:

What activities now carried by graduate staff nurses can be delegated to other members of the nurse personnel staff or to non-nurse staffs in the hospital; and which activities can be dropped entirely?

In planning with others concerned with the study of this problem it is decided that the first step is to find out what staff nurses really do. In order to do this ways must be devised to find out how nurses spend their time on duty. Actual facts must be collected, not just opinions. The head nurse's *opinion* about the matter may not be at all accurate. Collecting facts

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about what nurses do is not so simple as it sounds. A lot of time and energy may be spent just figuring out *how* you will collect the facts. The reports of similar studies done by other persons will be reviewed to see if this study can be tackled in the same way. The advice of experts will be sought. The whole matter will be discussed with the groups in the hospital who are concerned.

When it has been found out what the nurses on the ward do and how much time they give to various activities, decisions must be made regarding what activities can be delegated to other workers, which, if any, should be dropped. This question, too, is not simple. After it has been decided what activities can be delegated to other workers and which should be dropped, the head nurse will want to try out the new plan on her ward. The trial of the new plan will probably uncover certain weaknesses in it. Learning the weaknesses through actual trial indicates the need for modifying the plan to strengthen it.

This example of the several steps in the systematic study of a nursing problem is too simplified but it recalls the steps that most of us have all used from time to time in our work. Many times we plan to study a problem as systematically as this, but too often do not carry out our plans for a variety of reasons. Let me give you an example, quite different from the last, which shows the method of arriving at a solution to a problem in a manner which is not systematic and thoroughgoing.

Too often we turn to tradition and authority for the answers to our nursing problems. For example, supposing a hospital wants to develop a new procedure for the care of thermometers. The director of nursing service it apt to write to a few other directors to find out what procedures *they* use. She often adopts one that seems satisfactory without first inquiring *why* the hospital from which she got the idea adopted that procedure, and whether or not its merit has been proved — by bacteriological studies, for example. "If *that* hospital used the procedure, it is good enough for me," says the inquiring director.

Or, take another illustration. Some years ago I taught nursing arts. One of the procedures I taught every class called for the whisking of mattresses with a solution of mercuric iodide after a patient was discharged from hospital. This procedure was awkward to carry out in a crowded ward but it could be done. In fairness to those of us responsible for the teaching I must say that we did wonder what the purpose of the procedure was. If it was simply to lay the dust, water would have done as well. But we had inherited the procedure — "It had always been done that way." We had nothing better to suggest, nor did we even take the initiative of inquiring why the procedure was needed. I hope that these days nurses are expected to question procedures that seem ill-suited to the times or to patient needs, and that nursing students learn the importance of knowing *why* procedures are carried out in an accepted way. Some of us can remember the time when students felt they were not supposed to ask questions.

It is becoming increasingly clear that just because a procedure or policy has been in use over the years is not a justification for its continuance. Tradition and authority are not necessarily valid means of finding the best answers to problems in nursing. We are continually faced with new problems, the like of which we have not seen before. Therefore hand-me-down answers don't fit. Listen to what Alfred North Whitehead has to say about change:

> The point is that in the past the time-span of important change was considerably longer than that of a single human life. Thus mankind was trained to adapt itself to fixed conditions. But today this time-span is considerably shorter than that of human life. Accordingly our training must prepare individuals to face a novelty of conditions.

The quotation from Whitehead tells us very pointedly why research is receiving so much more attention in nursing today than it did years ago. The quotation tells us, too, why we nurses must take more initiative in the systematic study of problems. In the past, nurses have responded to changes initiated by others — for

example, the hospital administrator or a doctor deliberately set out to initiate study of nursing problems. There is every reason to feel that now the hospital administrator and the doctor expect the nurse to take the initiative in tackling nursing problems. If a patient's criticism of his nursing care could have been avoided by a more adequate in-service education program for nurse personnel the administrator may be justified in believing that nurses should have been developing an adequate in-service program before patient criticism arose. Today nurses at every level, not just those in administrative positions, are expected to come up with promising ideas for the solution of problems. Everything points to the fact that nurses will be held even more accountable in the future for identifying problems in nursing care and for suggesting ways of studying them.

What are the most perplexing and stubborn problems nurses are meeting? Is high staff turnover one? Lack of satisfaction in work? Patient care that does not meet acceptable standards? The fact that an established program for nursing care no longer fully meets the needs of the patients being cared for? More untrained than trained nurse personnel? Lack of adequate provision for training nurse personnel on the job? Inadequately planned teaching programs for patients? Making the most of clinical experience in the program for nursing students? Making instruction in the physical and biological sciences more meaningful for students in their care of patients? Determining the role of nurses in hospitals where there is a shortage of interns? Changing the functions of the public health nurse as the situations she meets in the home indicate?

The problems I have mentioned so far are those that might be tackled on a broader basis — in a province, or in the country as a whole. If tackled on a broad basis, the conclusions should be applicable to a large group of agencies and schools of nursing and, therefore, the research should, theoretically, have more significance. However, experience has proven that often those studies tackled in a small way have more chance of actually improving nursing practice than large scale research that is not applied in local situations to the extent it should be.

With the rapid changes going on in the health care of people, including changes in the functions of doctors, the major problem before nurses today is not limited to what the functions of nurses are *now*, but also, and more important, what they are going to be and *should* be in the light of public need. Shall the nurse continue to take on functions that the doctor is releasing? The trend in this direction is unmistakeable. If the nurse does not assume these functions being released by the doctor, will another group of workers have to be trained to do them? Certainly we see much more clearly than we did even a few years ago that nursing is only one part of a group of health services. Only through joint planning, study, and experimentation can we do the best job of finding the answers to our problems. This is as true in the ward, clinic, home situation as it is on the provincial and national levels. We see more evidence of joint planning all the time.

Basic and important research in *education* for nursing is dependent on a well-thought-through point of view concerning the functions of nurses in tomorrow's world. After all education aims to prepare nurses to carry certain jobs. There is little doubt that, as we see more clearly the evolving functions of nurse personnel for the years ahead, our educational programs can, will and must change. We are already asking ourselves searching questions about the adequacy of our present pattern of education for nursing, and are doing some experimentation.

The importance of practising nurses tackling the problems as they meet them in their jobs has already been mentioned. Education for nursing, too, can help. Basic nursing programs are beginning to assist students to develop facility in figuring out nursing problems as they arise instead of teaching them rule-of-thumb procedures. Students are being encouraged to ask questions about their work. In graduate education for nursing we are

introducing courses in research techniques and providing experience in the use of the techniques. Universities are beginning to stimulate, conduct, and coordinate studies in nursing. This is the purpose of the Institute of Research and Service in Nursing Education with which I am associated.

Nursing organizations and governmental agencies are taking an active interest in research in nursing in a number of ways. Agencies giving nursing care, too, are conducting studies to improve their services. Fortunately there is a healthy growth in the number of reports of studies being made available. Individuals, organizations and agencies are beginning to report completed studies. Nevertheless there are all too few studies in the nursing service field — both public health and hospital. The dearth is serious since the nursing service field is experiencing critical dislocation. We cannot encourage strongly enough that service agencies make known the results of their studies in order that others may benefit from the reporting. It is a moral obligation on the research worker.

Many resources are developing for those who, wishing to embark upon research, want expert consultation service. Provincial or national nursing organizations can give advice on where to go for assistance. Universities are taking an increasingly more active role in providing assistance to groups who wish consultation service.

In summary, I quote an excerpt from an article by Charles F. Kettering, called "What is research?" Mr. Kettering has been prominent in industrial research in the United States for many years.

> Research is a high-hat word that scares a lot of people. It needn't. It is rather simple. Essentially, it is nothing but a state of mind — a friendly welcoming attitude toward change. Going out to look for change, instead of waiting for it to come. Research, for practical men, is an effort to do things better and not to be caught asleep at the switch. The research state of mind can apply to anything. Personal affairs or any kind of business, big or little. It is the problem solving mind as contrasted with the let-well-enough-alone mind. It is the composer mind, instead of the fiddler mind; it is the "tomorrow" mind, instead of the "yesterday" mind.

May we in nursing cultivate and encourage the "tomorrow" mind!

Make Great Things!

GEORGE MATTHEW ADAMS

THERE ARE CERTAIN BOOKS I pick up in my library to inspire and give me a lift, the same as I hunt out many a friend and seek his or her kindly encouragement and counsel, I have mentioned this book before but want to quote from it again. It is called "The Art Spirit" by Robert Henri — a great artist no longer with us in the flesh, but one who will be to thousands in the spirit for so long as a great character lives. The book was published many years ago by J. B. Lippincott Co., Philadelphia. It has gone into many editions and I hope it is still in print, for it deserves to be.

This is what Henri told his students :—

"Go to your work because it is the most important living to you. Make great things — as great as you are. Work always as if you were a master, expect from yourself a masterpiece." What Henri meant by a "master" was a man who loved his work — and lived it — like a painter, carpenter or gardener.

We don't have to have lots of money or be famous to make great things, create masterpieces and therefore be known by ourselves as "a master" — we just have to put our heart into what we do, and do our best, trying always to do better, but always getting enjoyment out of the day's work, doing what we can to instill spirit into all those with whom we come in contact.

We are successes if we feel success in our heart and soul. We are useful and worthy if we contribute hope, a little comfort and a little inspiring knowledge to those who have known little of these things before. We should get into the habit of learning more and more from ourselves. Who knows us better than we do ourselves? There is such a thing as being a good companion. If we can live peaceably there may come a time when we may learn that in ourselves is that one best friend of all!

Play - An Essential of Every Child's Life

PATRICIA LAW

PLAY, PLAY THERAPY — what do these words mean? To frolic, to exercise, to amuse one's self, to create, to perform and to have fun, are all part of the life of the child, and too, they are all part of play. "Play is an activity through which physical vitality, creative activity and emotional growth is achieved (resulting in) development of a wholesome personality and the ability to adjust satisfactorily to the world in which he lives."[2]

Play life can be divided into three periods. First, there is *solitary play* where the young child plays alone with his toys and appears oblivious to his surroundings. Later, possibly around the age of three years, one child will play alongside another, maybe with the same type of toys such as cars or dolls, but still each will be playing separately. This is known as *parallel play*. The third type, *cooperative play*, is observed as the child becomes four to five years of age, and begins to participate in activities with a friend, or in small groups. Regardless of a child's age, a parent should try to understand the important place that play holds in his youngster's life, and encourage interest in the right fields.

Play therapy is a department of medical treatment which is designed to provide opportunities for the well adjusted, the emotionally disturbed, and the mentally retarded children in education, socialization, and mental assessment. The children are taught to play in a constructive manner with toys suited to their physical, mental and emotional capacities. Play periods have regular schedules with time for free active play, time for quieter more thoughtful play, and finally, a short, musical period. Through this supervised play, the child is gaining in muscle coordination, as when riding a bicycle; learning to extend his time of interest with a toy; and also, he is receiving an appreciation of music. Through the few restrictions in the Play Therapy Department, as in allowing the child to have only one toy at a time and returning it to the shelf before reaching for another, each tot is unconsciously being prepared for the limitations he will face later in life. Both mentally retarded and emotionally disturbed children need group participation. This necessity is gained in the Play Therapy Department through the sandbox activities and the music circle.

In the Play Therapy Department at the Children's Hospital, one finds many different types of children, ranging from two to sixteen years. The mentally retarded and emotionally disturbed children come into the Department to learn socialization and mental assessment. The cerebral palsy child attends play therapy to help him achieve muscle coordination, and, most important of all, to give him the opportunity to play with other children, thus building a firm foundation from which he may step forth and meet others outside the hospital. When a child reaches the convalescent stage, providing his condition permits it, he is allowed to come down to the play periods from the wards. This added attraction in the hospital day helps to quicken his recovery time in a pleasant way, whether it be physically, mentally or emotionally.

The supervision of the activities of such a varied group of children is a tremendous job for an adult. At all times this older person must remember to stay in the background and only come forward to aid a failing child to achieve his goal. For example, if a child is putting a puzzle together and appears to be having some trouble, the adult may assist by placing his hand over the child's hand and directing the puzzle piece into the correct space. In this way, the child will feel that he has accomplished this move

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Miss Law recently completed her training at The Children's Hospital, Winnipeg, Man.

and will, therefore, be encouraged to continue the puzzle. An older person, however, should show her presence and authority in a case where one child is disturbing a playmate, or where a quarrel must be settled.

At times, an adult may find it necessary to stimulate a new interest in the child to keep him happy, but she, again, must remember to suggest a game or action and not present it forthright to the child. If, at some time, parents find a child crayoning all over the newly wall-papered living-room, they should not charge upon the "little monster," even if at that moment he truly is, shouting, "No, no, no, Herman! You are a bad boy and Mummy is going to spank!" Instead, in conjunction with some form of discipline, divert the child's attention to a clean piece of paper on which he can crayon all he wishes and thus express himself. At all times when teaching or playing with a child, the adult must remember that he is an individual and cannot be expected to do the same things at the same time as his brother or cousin has done before him.

A parent or supervising adult should try to direct the child's play with the aim of achieving good physical, mental, social and emotional health in that particular child. Different activities during the play period will help to improve his posture by strengthening his abdominal and back muscles. While swinging happily on an acrobatic ring. Tommy is unconsciously strengthening his whole body. Through such varied activities as building blocks, painting and bicycle riding, the child learns to control and operate his body as he wishes. As may be well imagined, a normal active child will receive adequate exercise during his play time.

A child's social development begins at an early age and can be traced through his play habits. A two-year-old prefers to play alone, exploring things and learning new ideas about his home, his family and himself. As time goes on, he may enjoy being in the room with other people or even standing watching them, but seldom does he participate in the game. It is excellent for children to play together and with each other's toys for this provides an opportunity to show ownership and the "social rights of sharing." "Children learn more readily from the direct give and take with other children, rather than from the adult.[2]" There should be variety in the child's play groups, giving him an opportunity of being a leader of younger children, and yet at another time, following an older group. "A child's social development depends not only upon his experience with other people, but also upon his ability and skill in active play, along with his understanding and consideration of others.[2]"

When considering a child's emotional health, one first must establish a good home background, thus giving him an opportunity to develop a feeling of security and dependability. It is a known fact that often an emotionally disturbed child will accept a new situation out of the home quite readily, thus showing actual relief at being out of his home. The Play Therapy Department provides an excellent opportunity for such a child to develop his personality. A selfish, domineering child will not succeed in gaining friendship with other children and will, as a result, become more cooperative and considerate of his playmates.

Play is an essential of childhood and toys are the tools of play. "The outstanding change in education in the past 15 years or so has been that we have added a fourth "R" to the former three. It is now, "Reading, 'riting, 'rithmetic and recreation. With this growing increase in the importance of play, has come a realization of the educational value of toys and play materials[1]." In the Play Therapy Department there are normal children recuperating from their illness; there are cerebral palsy children, mentally retarded children and emotionally disturbed children. When choosing a toy for one of these young persons, first consider their physical and mental abilities; secondly, the age and sex; and finally, the durability and safeness of the toy. A young child recovering from an appendectomy or a herniotomy would enjoy doing a picture puzzle, or playing a game of Chinese Checkers, but should not, of course,

be allowed to ride around on a bicycle or stand at the sand-box for long periods.

The spastic child's toys should aim to help muscle coordination and exercise. Finger exercises may be accomplished by stringing beads, screw-top toys, or by participating in finger actions in the musical songs such as "Dance Little Fingers." As the child progresses and more muscle control is developd crayons, plain paper, and large picture puzzles would be advisable. Play exercises to help in leg muscles control could be achieved through bicycle riding or in walking while pushing a chair in front of him. These toys should help the cerebral palsy child gain the physical coordination that his body lacks and yet, at the same time, give him many hours of enjoyment.

In the Play Therapy Department we receive a number of children who are emotionally disturbed and, as a result, are often behavior problems. These children differ greatly. Some may be destructive and noisy, while others may tend to be introverts and prefer to play alone. In the first case, the hyperactive child should be given such toys as a hammering block, plasticine or cars with which to play. In this way, they will be burning up their energy and getting rid of their pent-up emotions. A quieter child must be brought into activity with other playmates in small groups at first, and gradually to a larger, more active group. He may enjoy playing "Fish" with another child. As time progresses, he should be encouraged to join the music circle and participate in the actions along with the others.

When playing with a mentally retarded child, the first essential is to know his mental capacity and limitations. Like the emotionally disturbed child, he may be either noisy and hyperactive, or quiet and reserved. The colored fitting cups would be a good toy for a mentally retarted child, for this single toy provides many educational opportunities. First, the child must learn to place each cup in its correct position according to size — be able to fit them together. Once this has been accomplished, he could be taught to count and name the colors of these cups as he is fitting them together. On the bottom of each cup there is a picture of a dog, cat or horse, etc., which helps to teach the child the different animals he may find on the farm.

Peter

Let me take Peter as an example of a young child who is being helped in the Play Therapy Department. Peter is a chubby, pleasant, four-year-old. He was born with a cleft palate that has had a plastic repair. He attends Speech Therapy classes from 1:30 p.m. to 2:00 p.m. Monday through Friday. Then he comes into the playroom for the rest of the afternoon. Prior to his attendance at the speech classes Peter was able to make sounds that were understood only by his mother. It is felt that his present retardation of speech is due more to an emotional factor than to a physical disability. On first entering the playroom, Peter accepted his new environment fairly well, but appeared to require the presence of adults. He tended towards solitary play using large toys, such as the elephant or the train. He appeared almost oblivious to his surrounding at times, concentrating on his toy, making wild motions with his arms, and uttering loud, unintelligible noises. On adult suggestion of smaller educational toys, he became resistant and turned back to the train. If asked to say what he would like, he would make no sound whatsoever and look away.

In my observations during the three weeks in which I played with Peter, I felt that his emotional instability had improved slightly, but that his speech had shown little change. He has now mastered many of the educational toys and appears to enjoy playing with them. He still needs adult suggestion to participate in group activities, but will now occupy himself for a short time with his selected toy. Peter is very meticulous, and takes great care in replacing everything as he found it. Fortunately he no longer gives the loud shrieks while playing. He will, if spoken to, try at times to tell us something.

Having had three weeks in the Play Therapy Department, I feel that this educational period has given me the opportunity to realize the importance of play, and the selection of toys

for individual children. I doubt if it is generally realized or appreciated how much thought, reasoning and patience must be exercised when playing with children. I think that this period has made me conscious of these important factors. In the future, I would like to have further opportunity for study and interest in this particular field of medical treatment.

REFERENCES

(1) The Wise Choice of Toys by Ethel Kawin.

(2) Your Child's Development and Guidance by Lois H. Meek.

Spills and Dribbles Avoided

It is not easy for a baby to drink from an ordinary cup or glass. Like all humans, he resists change. Why should he bother to drink his milk from a cup, when he is accustomed to taking it from the breast or the bottle? Besides, his tiny, bud-like mouth doesn't fit comfortably over an adult's drinking glass or cup. What a trying time for mothers! However, many mothers are being helped over this stage with a new baby tumbler that is ideal for this period. It avoids the spills and dribbles of infant drinking habits.

Easy to Use

This convenient tumbler is smooth and round like a nursing bottle and is made of durable plastic with a removable top. This top is molded with a perforated spout-like mouth-piece, through which the baby drinks his water, milk or fruit juices without spilling them. The tumbler is so easy to use! The little tykes enjoy it! And it's safe and sanitary too. Fastidious mothers will approve of this innovation, because it cuts down on the laundry work and forestalls frayed nerves, resulting from annoying spills.

These tumblers may be secured in various colors — the traditional pink for girls and blue for boys. The pink and blue tumblers are opaque.

It is wise to let the baby learn how to use the tumbler by experimenting with a slow introduction. In the beginning, set the tumbler on his tray at feeding time. He'll soon become interested in it — may even put it to his mouth. This new discovery will please him. Next pour his fruit juice into the tumbler for his experimentation. When the flow of juice through the spout is mastered, try his milk. In no time he will be free from the routine of nursing bottles. When the baby has outgrown the use of the spout on the tumbler, the top may be removed leaving an attractive conventional type of toddler's cup.

This tumbler, approved by the medical profession, is offered as a premium.. Many mothers who have used it have stated "it's worth all the money in the world — my baby has learned to drink from the tumbler in less than a week."

— *Public Relations Department,*
H. J. HEINZ COMPANY OF CANADA LTD.

The new-drug applications filed in the past 17 years have recorded an era of unequalled progress in pharmaceutical research and development. This period — first marked by the introduction of the sulpha drugs and then by the antibiotics — has truly been an era of "miracle drugs." More than half of the drugs in use today were unknown 17 years ago. These new tools have made possible revolutionary changes in medical practice, changes that are adding years to the life span of people all over the world.

— U.S. DEPT. OF HEALTH,
EDUCATION AND WELFARE

The Elements in Program Planning for Conventions

HELEN M. CARPENTER

EVERY ORGANIZATION or association is concerned with the problem of program planning for conventions. The responsibility for this aspect of association work is usually assumed by a program committee. What are the major considerations of this committee? What are the elements that must be considered in program planning? The following points will be discussed in some detail:

The purpose of the convention
The audience
The program
Publicity and public relations
Social values
Accommodation and reception of delegates.

THE PURPOSE OF THE CONVENTION

Before considering the purpose of the convention it is desirable to review the over-all objectives of the organization. From such a consideration, the objectives of the convention may be formulated. Conventions may be held with the following aims in view: To develop and strengthen the organization by providing an opportunity for discussion of its purposes and progress; to provide an opportunity for reviewing the work of the organization and for the election of officers; to contribute to the education and inspiration of the members; and to strengthen relationships within the organization and with the public.

THE AUDIENCE

One of the first considerations in planning a program is the character of the audience or group for which the meeting is being arranged. Information concerning the approximate number who will attend, the sex, age, professional experience and expressed needs of the delegates is important to keep in mind. It is of interest to note that an analysis of statistical data with respect to nurses with membership in the Canadian Nurses' Association indicates that 55 per cent are under 35 years of age. Attendance at a biennial meeting is approximately 1100.

PROGRAM

The program committee is appointed by the executive of the association and is responsible to the executive board. The committee consists of representatives of the executive, the major committees, and the secretarial staff of the association. The president and executive secretary are key members.

The first step in program planning is the selection of a theme. For the 1956 biennial this is — Nursing Serves the Nation . . . L'Infirmière Sert la Nation. The theme expresses in a few words the topic that will be highlighted during the convention. One objective in choosing a theme is to provide inspiration. Other purposes are to secure continuity in the meetings and to assist in the development of public relations. When planning on a national level, consideration is given to the meaning and rhythm of the theme in English and French.

The program is arranged around the theme, with consideration for the purpose of the convention, the resources of the organization and the profession, and the audience. Opportunity is provided for reports of association affairs, for election of officers, and for resolutions. An important objective of the program is to make possible the discussion of current nursing developments, problems in nursing service and nursing education, and nursing research. A suggestion of assistance in providing continuity and an opportunity for concentration of

Miss Carpenter, who is an assistant professor in the University of Toronto School of Nursing, is chairman of the Program Committee of the Canadian Nurses' Association.

content in one field, is to plan a day around each topic. The interest of the delegates is stimulated when there is time for questions and group discussion.

A recent international convention utilized the following plan effectively. The periods were divided into general sessions and discussion groups; all sessions were brief. A topic was presented by panel discussion or some other suitable method. This presentation was followed by general discussion. Following general discussion, small groups were organized under the leadership of persons selected in advance for this role. This gave an opportunity for those interested to learn more about the topic under consideration. Later in the day the subject was brought to a climax by a scholarly address. There was time for further discussion in small groups if this was desired.

The topic, the amount of time for discussion, the method of presentation, and the choice of persons to participate in the presentation are all important. It is desirable to secure some speakers who are recognized authorities in their own field. It is also of interest to plan presentations that will give an opportunity for the participation of several experienced members of the profession, and will introduce variety in the program. Forums or panel discussions, dramatizations, films or other visual material contribute to the content and interest of the program.

The responsibility for planning various sections of the program may be delegated by the program committee to an interested group or a committee of the association. Such a committee is responsible to the program committee and should report progress at intervals. Delegation of responsibility increases interest in the convention and distributes the work associated with the program. It also provides an opportunity to secure participation from nurses not regularly engaged in organization work. Any plan to extend participation through committee work, the preparation of demonstrations or exhibits, or in other ways, increases the interest of the members and a feeling of belonging to the association.

Publicity and Public Relations

One factor that should permeate all aspects of program planning is publicity and public relations. The content of the program should be selected with a view to public interest. Of current and general interest are such matters as emergency preparedness and civil defence, the problems of nursing education, the demands for nursing service. A convention is a time to assist delegates to understand the importance of public relations, to increase public interest, and to interpret to the public the concern of nurses for maintenance of a high standard of service. Newspaper, radio, and television publicity should be sought and guided in the light of the interests of the profession and the public. In addition, interpretation of the convention to the members of the association should be undertaken with a view to stimulating interest and attendance at the meetings. Articles concerning the convention program and place of meeting, copies of the program, and reports to be presented for discussion should be prepared and published well in advance.

Social Values

A convention should have broad social values. It should stimulate the delegates to think beyond their immediate problems and those of the profession to matters of social interest. As well as providing an opportunity for formal and informal discussion, for suitable social gatherings, and the stimulation that results from "coffee breaks," lunches and dinners, a convention should provide inspiration and assist the delegates to glimpse new horizons. The Mary Agnes Snivley lecture serves this purpose at biennial conventions. An outstanding speaker is chosen and requested to give an inspirational address on a topic of broad social interest. It is arranged that the lecture will be given toward the end of the convention, at an impressive occasion such as the closing banquet or an evening reception.

Accommodation and Reception of Delegates

It is trite to observe that the success of the best planned program rests on

such factors as the suitability of the location of the meetings, the accommodation available for the delegates and the general atmosphere of friendliness and concern for welfare so important to all relationships. Usually this aspect of program planning rests with an arrangements committee and the executive staff of the association. Details concerning meals, transportation, recreation, and individual needs in relation to religious observance, must be considered with meticulous care. An atmosphere of friendliness and efficiency, from the time the delegates begin to arrive till the last one leaves for home, contributes to the success of the convention, and to general interest in belonging to the association and participating in its work.

These are but some of the elements in program planning. The concern of your national organization is to plan conventions that will interest nurses across Canada and provide an opportunity for participation, stimulation and inspiration so that nursing will grow as a profession and continue to earn the respect of the nation.

Transaminase

In heart attacks, damaged heart muscle signals the degree of its distress by the release of an ennzyme called transaminase. By means of an improved test for transaminase in blood, scientists are now able to determine accurately the amount of heart muscle damage in victims of heart attacks.

Research workers have modified an earlier laboratory method for the detection of transaminase which was developed at the Sloan-Kettering Institute in New York and have carried out a critical evaluation of it as a clinical test for heart damage. Particularly important in terms of clinical usefulness is their adaptation of the method to a comparatively inexpensive, generally available spectrophotometer — a device for analyzing solutions by the quantity of light absorbed in passing through them.

By proving the usefulness of transaminase as a measure of heart muscle damage these researchers have made available to the physician a tool with unique advantages for diagnosing the extent and seriousness of heart muscle infarcts — areas of severe damage which follow the plugging of the coronary artery "supply lines" to the heart muscle.

To date the most valuable tool for this purpose has been the electrocardiograph which provides the physician with a record of the electrical current given off by the contracting heart muscles. The physician, by interpreting the behavior of the heart as seen on the electrocardiograph tracing, has been able to deduce the approximate extent and location on the heart of the infarct. However, since it does not always distinguish between temporary and permanent damage, the data from the electrocardiograph can be inconclusive. With the new transaminase test, the physician should be able to better determine the extent of permanent tissue damage. Using both methods it may now be possible to predict recovery and prescribe treatment in patients with heart attacks with greater effectiveness than has been possible with the electrocardiograph alone.

— U.S. Department of Health, Education and Welfare

We are apt to measure time by the yardstick of our own litetime, and fail to realize that such a yardstick is as inadequate as an inch rule would be for measuring the circumference of the earth. Since life began on this planet there have been successive steps forward, and since the early days of man these steps have led to a more adequate functioning of the human body and the human mind. The process continues so slowly as not to be perceptible within the compass of a human lifetime. But it continues, and will increasingly, aided by the conscious efforts of men and women of goodwill who strive for a better life. There will be disappointments ahead as there have been in the past, and at times the process may seem to have gone into reverse. But I have a firm conviction which to me is an article of faith, that no conscious effort towards betterment, whether individual or collective, is ever lost. It is held on the lap of time.

* * *

Nursing Profiles

Jessie Isabel Williamson is director of public health nursing services for the province of Manitoba. Born and educated in that province, Miss Williamson is a graduate of St. Boniface Hospital School of Nursing. She holds her certificate in public health nursing from the University of Manitoba and her B.S. degree from Teachers College, Columbia University.

Private nursing and a couple of years in the outpatient department at St. Boniface Hospital preceded Miss Williamson's entry into the field of public health nursing. Her first assignment was in an unorganized area where she learned to cope with bog, snow and isolated communities. After serving in some larger municipalities she became senior nurse with the health unit at Dauphin in 1945. In 1951 she was appointed nurse consultant for several health units and moved into the post of assistant director in 1954.

Miss Williamson's Irish ancestry has given her an even temperament and a quick sense of humor. To these may be added her ability to think through problems with clarity and definiteness. These qualities auger well for her success in the increased responsibilities she now holds.

JESSIE WILLIAMSON

Sister Mary Melanie has become the superior of St. Mary's Hospital, Montreal. Born in Morrisburg, Ont., Sister is a member of the community of the Sisters of Providence of Kingston. After graduating from St. Vincent de Paul Hospital in Brockville in 1935, she went to Providence Hospital, Moose Jaw, as operating room supervisor. Five years later she became obstetrical supervisor at St. Francis Hospital, Smith Falls, Ont., commuting back and forth to the University of Ottawa where she received her B.Sc. in nursing education in 1944. Sister Melanie also holds her master's degree in nursing education from Catholic University of America, Washington, D.C. Recently she acquired her Certificate in Hospital Organization and Management.

SISTER M. MELANIE

Sister has been on the staff of St. Mary's Hospital for the past eleven years as director of nursing education, a post she is now combining with her new duties, and science instructor. She always has taken an active part in nursing association work, particularly in relation to the improvement of the curriculum for schools of nursing. The leadership she will be able to give in her new post because of her intimate knowledge of every facet of hospital life will be of great assistance in the new construction program on which St. Mary's has launched.

Sister Jeanne Quintal, s.g.m, is now the director of nursing at St. Paul's Hospital, Saskatoon. Born at Varennes, Que. Sister Quintal graduated from Notre Dame Hospital, Montreal, in 1942. She received the degree of Bachelor of Science in nursing education from the Marguerite d'Youville division of the University of Montreal and was assigned to a supervisory post at Holy Cross Hospital, Calgary. In 1947 she transferred to Saskatoon where she has served as clinical instructor, medical supervisor and assistant administrator before assuming her present duties.

Florence Taylor, who 17 years ago went to India from Brantford, Ont., under the auspices of the United Church of Canada, last summer was awarded the coveted Florence Nightingale medal by the International Red Cross for outstanding work in nursing. Dean of the university school of nursing at Vellore Christian Medical College in South India, Miss Taylor organized and developed a four-year course leading to a degree in nursing for the native students.

SISTER JEANNE QUINTAL

In Memoriam

Ruby Pearl (Weedburg) Burns died suddenly at her home in Carp, Ont., on August 22, 1955.

* * *

Catherine Campbell, who graduated from Sarnia General Hospital in 1901, died at St. Thomas, Ont., on September 5, 1955. Miss Campbell worked in Revelstoke, B.C., at one time and later was on the staff of the Toronto branch of the Victorian Order of Nurses.

* * *

Mary Elizabeth Cardiff, who graduated from Royal Jubilee Hospital, Victoria, in 1953 and from the public health course at the University of B.C. this year, died September 9, 1955, from injuries received when her car went out of control near Castlegar, B.C. She was 24.

* * *

Frances Effie Derick, recently on the staff of Charles Camsell Hospital, Edmonton, died on June 28, 1955.

* * *

Alice L. Drainie, a native of Fergus, Ont., who trained in Chicago, died at Vancouver in August, 1955. During World War 1 Miss Drainie was matron of the Military Annex of Vancouver General Hospital.

* * *

Hannah Ford, formerly of Portneuf Village, Quebec, died in November, 1954.

* * *

Marjorie M. Gorham, who graduated from Royal Victoria Hospital, Montreal, in 1922, died on September 30, 1955.

* * *

Beryl Kathryn (McFalls) Griffeth, a graduate of St. Joseph's Hospital, London, Ont., died on September 25, 1955, after a lengthy illness.

* * *

Alice P. Hegan, a graduate of the Newton (Mass.) Hospital, died at Shediac, N.B., in August 1955, after a long illness. During World War 1 Miss Hegan served on hospital ships. For many years she was associated with the Saint John Tuberculosis Association, retiring in 1938.

* * *

Rita Newton, a staff member at the Sudbury-A'goma Sanatorium was killed by a moving freight train on September 24, 1955. She was 24 years of age.

Sister St. Stanislaus, who graduated from Hotel Dieu Hospital, Chatham, N.B., in 1933, died there recently after a rich and devoted life of nursing service.

* * *

Atlanta Sollows, who graduated from Emily Balch Hospital, Plymouth, N.H., in 1912, died at Saint John in August, 1955. Realizing many years ago that her health would not permit her to continue active nursing, Miss Sollows turned to chiropody. She became an expert in making beautiful shell creations of all kinds, also.

* * *

Myrtle (Manser) Vetter, who graduated from Kitchener-Waterloo Hospital in 1916, died there on September 15, 1955 at the age of 64.

HOW BIG IS MAN

How big is the world?

"A little less than 25,000 miles around, at the Equator," replies the geographer confidently. "Its mass exceeds six sextillion tons, not counting the atmosphere. Surface area is about 179 million square miles, of which less than 58 million is dry land," interrupts the agricultural statistician. "Subtract the mountains, deserts and arctic wastes and there is not much left to support mankind — some 33 million square miles, most of it not very fertile. So far as human needs are concerned, the world is too small."

"Ridiculous!" exclaims the chemist. "The world can supply enough food, clothing and lodging for three times its present population, with enough left over so that man can have leisure contemplation, cultural expression and spiritual development." The astronomer, the radio engineer and the aviator will tell you the world is small — but they won't mean the same thing. To the man with the hoe, to the weary traveller and to the frustrated, dispirited and infirm, the world is too big. The mountains are too high, the seas are too broad and the rivers too swift. Perhaps the real question is "How big is man?" for, in measuring the world, man really measures himself. Thus, one may say, "The rock is small enough to lift," while another declares "I can lift it." One measures the rock, the other measures himself.

— Peter DuBerg, *Editor, UNESCO Features*

In the Good Old Days

(*The Canadian Nurse* — December 1915)

"The deliberate and cold-blooded murder of Edith Cavell, the English matron of the Belgian Training School for Nurses in Brussels, by officials of the enemy, has aroused the indignation and called forth the condemnation of the civilized world. Nurses everywhere have felt personally bereaved and have sought to honor the memory of this nurse martyr. Over 600 nurses attended a special memorial service in Toronto."

* * *

"Beware of understaffing your hospital lest you be forced to lower the grade of your work! In so many hospitals the superintendent of nurses is expected to be housekeeper, bookkeeper, operating room nurse and the only nurse teacher. The result is that lectures and demonstrations are only given when it is convenient. Thus pupil nurses are the sufferers. Is it right? Is it fair?"

"It is the hope of the nurses of Ontario that after uniformity of training has been successfully introduced some way will be opened to establish a chair of nursing in a provincial university to enable Canadian nurses to extend their education along broader lines and to feel that in our country we can obtain any education in nursing to which our ambition may lead."

* * *

"At the annual meeting of the Nova Scotia Graduate Nurses' Association, with the consent of the Lieutenant-Governor-in-Council, the condition of membership has been changed. A nurse must now be a graduate of a 50-bed instead of a 40-bed hospital to belong. The object of this change is to exclude from membership all who are ineligible for military duty, the minimum required being 50 beds."

NURSING SERVICE

Double Formula Room

MARY KISSNER

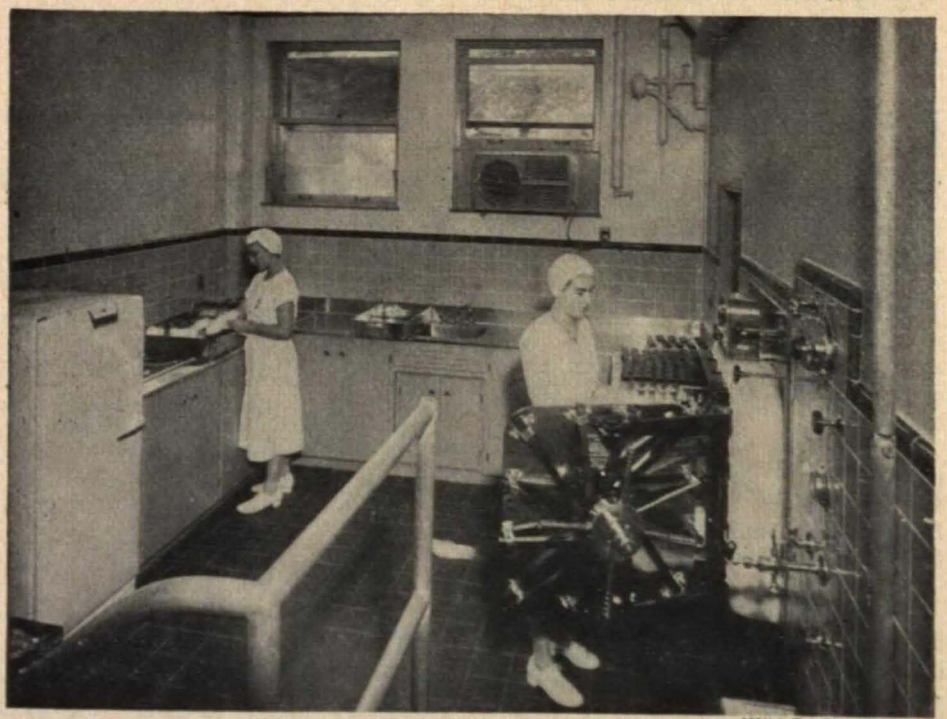
IT CANNOT BE SAID that hospitals do not have a product! Plump pink and blue bundles departing daily from the obstetrical department, with the very best start in life that the hospital can give, are a mighty contribution to any community.

The new double formula room at Windsor Grace Hospital fills an important role in this vital part of hospital service. Newly equipped, air-conditioned, conveniently arranged combined with employment of the most meticulous sterile techniques — all contribute to this scientific regime.

This double formula room is composed of two separate rooms, the "sterile room" in which the formula is made, and the "unsterile room" in which bottles, nipples and caps are washed.

The "unsterile room" is equipped with an automatic bottle brush and rinser, each helping to ensure true cleanliness of bottles. It is to this room that all bottles, nipples and caps are brought, including those from the pediatric department (which have

Mrs. Kissner is in charge of the formula room at Grace Hospital, Windsor, Ont.



Wild Studios, Windsor.

In the "Sterile" Room

been previously sterilized). These then are washed, rinsed and placed inverted on racks, in readiness to go through the auticlave. Nipples are boiled for three minutes, and empty bottles sterilized in the autoclave for ten minutes, before entering the "sterile room."

The "sterile room" is equipped with a refrigerator, in which all milk to be used for formulae is stored, thus ensuring freshness; a sterile water tank from which sterile, filtered water is obtained; a scrub-up sink, as well as sink with drain rack, on which bottles may be drained; two electrical elements built into the surface of stainless steel topped cupboards, where formula may be boiled if necessary.

It is in this room that formulae are made. Utmost care is exercised to prevent them coming in contact with any unsterile equipment. Masks are always worn.

Once formulae are made and the bottles filled with the designated amount, nipples and caps are put on. The bottles are placed in racks which are autoclaved from the sterile side. Formulae are in a constant stream of steam at 212° for 30 minutes. After this the feedings are ready for conveyance, in an especially designed carrier, to the nursery refrigerators. This conveyer is a closed, stainless steel container, designed for use in this hospital by Brigadier D. M. Barr, former superintendent.

The autoclave in the unit connects the two rooms, and has a door on either end, making it possible to place either formulae or unsterile bottles into it without coming in contact with the other room — further insurance of true sterilization.

The supervisor works from her own efficiency arranged and located desk and telephone. This department wishes each new citizen Godspeed with a card of instruction for his mother giving the necessary information regarding his formula and its preparation, together with a day's supply of formula.

Paget's Disease

C. Lawton *and* G. Rinker

Paget's disease, known also as osteitis deformans, is a chronic, progressive disturbance in bone metabolism, in which the initial phase of decalcification and softening is followed by calcium deposition with resultant thickening and deformity. Sir James Paget was the first to describe it in 1882, and despite careful study and survey little more is known of the cause or the essential nature of the disorder.

The onset is insidious. The disease usually occurs after the age of 30 or 40. Both sexes are equally affected. It has been observed that Paget's disease and diabetes frequently occur in the same family.

The outlook for life is good, usually, but the deformities may eventually lead to invalidism after 20 or 30 years.

Our authors are staff members of the General Hospital, Sarnia, Ont.

The basis of relationship between Paget's disease, and sarcoma of the bone has not been established, but recent surveys have revealed that 25 per cent of cases of Paget's disease have been followed by this sarcoma. It appears probable that the long-continued excitation of bone-forming cells expressed in unnatural proliferative activity, may lead to unrestrained neoplastic growth.

Among the various skeletal diseases there are few that give rise to pathologic changes that are as characteristic as the alterations noted in Paget's disease.

Signs and Symptoms

The disease is localized at the onset, spreading through the peripheral system until the entire bone is affected. It may be found in the long bones, spine, pelvis and skull. The condition

is characterized by tenderness and pain in affected bones, swelling and muscle cramps.

Early decalcification leads to softening and bowing tendencies. In the weight-bearing portion of the body there is anterior bending of the tibia, the femur bows outward, the spinal column becomes shortened and curved. As a result, the victim walks with a waddling gait and eventually is crippled.

Spontaneous fractures are not uncommon.

Uncontrolled recalcification leads to thickening and enlargement of the deformed bones. Enlargement of the cranial vault gives the face a triangular appearance.

Impairment of hearing commonly occurs.

Case History

Twenty years ago, following insidious onset, Mr. Stanley complained of pain in the lower spine and pelvic region. Gradually further changes in his bony system were noticed — particularly enlargement of the skull, deformities of the long bones and rigidity in some of the joints. Progressive deformity of the bones continued, causing him a great deal of pain and physical disability.

Today, Mr. Stanley, who is 70, presents the picture of a small, wizened, old man, with a very large skull and jaw, hunched back, and startling scissors deformity of both legs, so pronounced that they cross over at the knees. He is unable to abduct his arms above shoulder level. He has to transport himself around on crutches or by wheelchair.

A particularly cheerful man, whose condition does not seem to distress him unduly, Mr. Stanley's chief complaints are pain in his shoulders (which is relieved by sedative medications) and his state of deafness. He is confined to bed most of the time where he usually finds the upright position most comfortable.

There was no history of Paget's disease in his family, but it is rather interesting to note that it was recently discovered that his daughter had mild diabetes.

Drugs and Treatment

There is no specific therapy for Paget's disease. Parathyroidectomy is useless and contraindicated. X-ray radiation of the bones may ease pain. During the stage of decalcification, a diet rich in calcium and Vitamin D is indicated. Orthopedic exercises and appliances are used as needed. Cortisone or hydrocortisone have been used with benefit in some cases.

Metropolitan Health Committee, Vancouver

The following are staff changes in the Metropolitan Health Committee, Vancouver:

Appointments — To supervisory positions: *Phyllis Jones* (B.N. Univ. of Toronto); Mrs. *Grace Robinson* (Ottawa Civic Hosp., McGill Univ. course in supervision and administration); *Muriel Small* (M.A., Univ. of Washington). To the Streptomycin program: *Dorothy Hornibrook* (Royal Jubilee Hosp.); Mrs. *Mary Patterson* and *Annette Seymour* (St. Paul's Hosp., Vancouver). To staff positions: Graduates of Vancouver Gen. Hosp. and Univ. of B.C. — *Carol Bride, Charmaine Clugston, Joan Crawford, Oonagh Donald,* Mrs. *Jean Hardie,* Mrs. *June Talbot, Martha Theissen,* Mrs. *Shirley Warren.* Also, Mrs. *Frances Clegg* (St. Martha's Hosp., Antigonish, N.S., Univ. of Ottawa); Mrs. *Josephine Contini* (Red Cross School of Nursing and of Public Health, Rome); *Jane Cooley* (B.S.N. Univ. of Toronto); *Edith Fraser* (St. Paul's Hosp., U.B.C.); *Vivian Pontifex* (Royal Columbian Hosp., U.B.C.); Mrs. *Barbara Wadman* (Frances P. Bolton S. of N. and Western Univ. Cleveland).

Leave of Absence — *Florence McGeachie* from Burnabay to attend Univ. of Toronto for course in supervision and administration.

Resignations — *Marion Arnold,* Mrs. *Doreen Benham,* Mrs. *Bruna Cavacece, Virginia Cyr, Louella Downing, Mary Gardiner, Catherine Guimont,* Mrs. *Eleanor Heady, Melva Hughes,* Mrs. *Shirley Leonard,* Mrs. *Margaret McKenzie, Catherine Murray, Bessie Sherwin, Evelyn Teir,* Mrs. *Roma Worley.*

NURSING EDUCATION

Research In Basic Nursing in Canada

MARGARET P. MORGAN

BEFORE CONSIDERING THE QUESTION it would seem appropriate to clarify in our minds what is implied here by the word research and at the outset to define the limits of this discussion. The type of research that has been carried on in the basic nursing curriculum may be called action or applied research. Pure research and action research differ only in aims and objectives. The methods employed in each are similar. Such programs of action or applied research in nursing in Canada are few. In addition to a consideration of three of these programs it would seem appropriate to further indicate trends in nursing education by including a discussion of some so-called experimental patterns in teaching methods now being used in the basic course, but which have not been set up primarily as research projects.

With the establishment of these research and experimental programs one might logically ask, "What problems in nursing education have been selected for study?" These problems are familiar to all members of the nursing profession, but once more they need to be enunciated to bring into sharper focus the accomplishments of certain research activities. The main problems fall simply into three very obvious categories. They are directly related to:

1. The organization and control of schools of nursing.
2. The curriculum.
3. The quality of teaching and the number of prepared teaching personnel.

With few exceptions schools of nursing across Canada do not exist as educational institutions. A school *should* exist for the purpose of fulfilling its aims of providing an educational experience for its students. Schools which lack administrative and financial independence cannot perform this function and hence a purposeful curriculum cannot be evolved. Over the years this problem has been well understood by those charged with the responsibility of planning programs in nursing education. Favorable influence resulted from the Weir report published in 1932. This survey of nursing education in Canada was the first research program undertaken by our professional organization. Recommendations advanced as a result of this survey included the following:

1. That schools of nursing should function as educational institutions.
2. That the school of nursing should operate on a separate budget.
3. That the responsibility for nursing education rests with the state.

Generally speaking, these recommendations have not been put into effect. This inability of a school to exist in its own right has been one of the chief obstacles to reform.

Curriculum planning constitutes a second major problem. It is a difficult task to provide adequate preparation that will enable the professional graduate to serve well, and to her own satisfaction, in a complex and changing society and that will enable her to meet the demands resulting from continual change in scientific medical research. An analysis of the needs of present-day students presupposes a faculty organization where its members are free to devote time to thoughtful study. Specifically, the curriculum

Miss Morgan is educational director, Hamilton General Hospital, Hamilton.

in action should allow for the development of initiative and independence. It should prevent prejudice and closed minds. It should not resolve into a systematic collection of factual material, but should be capable of stimulating interest in major problems in society. Certain forces, such as systems of mass communication and the power the printing press, present themselves as problems to all educators. Recognizing the existence of these problems it may be said that, in the field of general education, curriculum development is dependent in a large measure upon the intellectual capacity and capabilities of the teaching staff and students. In most schools of nursing curriculum development is circumscribed by a further limitation which is truly binding, that is, the existing patterns of organization and control of schools. The source of this curtailment is inherent in one basic problem, namely, a lack of autonomy in organization and control of most schools of nursing across Canada and, indeed, throughout the world. As long as directors and staffs of schools of nursing are continually harried and exposed to frustration, progressive development of the basic nursing curriculum will be retarded. The proverbial vicious circle will be perpetuated.

A third major problem of schools of nursing pertains especially to the quality of teaching and the number of prepared teaching personnel. It is important that the integrity of our schools be safeguarded by faculty members who possess scholarship, knowledge, foresight and understanding. Tomorrow's teaching staff will be the graduates of today's schools. As long as the basic course is deficient for reasons already discussed prospective administrators and teachers in schools of nursing will be inclined to seek additional preparation of a nature that will make up for these deficiencies. All this is very costly in time, effort and money. It would seem that further preparation of faculty members of schools of nursing should be based on a knowledge of principles and a search for truth. This presupposes a sound foundation on which to build. It follows therefore that the organized profession is charged with the responsibility of seeking a solution to those underlying problems which at present retard improvement in the basic nursing curriculum. The nursing profession through the schools of nursing must concentrate on the development of capacities to resist the influence of inertia and mediocrity.

It will be seen that these three problems are inextricably bound together; likewise their solution. Looking to the future, however, a fairly wide-scale practice of remedying the first problem would act as a liberating force and would expedite the achievement of the other two.

The first independent schools of nursing in Canada were established under the sponsorship of universities. Three such schools are in operation in Ontario where the university assumes full responsibility for the planning of the basic nursing course. The University of Toronto School of Nursing was established in 1933, the University of Ottawa School of Nursing in 1940 and the McMaster University School of Nursing in 1946. Primarily, the aim of each school is to provide a sound basic professional course. These programs have fulfilled a long-felt need, but relatively speaking the number of students being graduated from these schools has been limited.

Long dissatisfied with basic programs in hospital schools of nursing in Canada the Canadian Nurses' Association undertook the demonstration of an independent hospital school of nursing. Financial assistance was provided by the Canadian Red Cross Society. The objectives of the Demonstration School were:

1. To establish nursing schools as educational institutions, separate entities in their own right.
2. To demonstrate, if possible, that a skilled clinical nurse can be prepared in a period shorter than three years, once the school is given control of the use of the student's time.

The evaluation of this basic program shows without doubt that when a school exists as an educational institution, with full control of its students, better clinical nurses may be prepared in a shorter time than three years. One should not lose sight of

significant contributing factors which influenced the outcome. The administration of this school was in the hands of well qualified, competent staff who planned and directed a well integrated curriculum designed to provide a balance between theory and practice that was educationally sound. It would seem that all available facilities were used to the best advantage. The principle of educational independence has now been demonstrated in both a university and a hospital school of nursing.

In 1950 a second experimental program in the basic course was established in a large hospital school of nursing. The evaluation of the Demonstration School at Windsor had shown that when a hospital school existed as an educational institution the clinical nurse could be as well if not better prepared in less than three years. It was felt that these findings could be applied in another situation and at the same time further investigation could be carried on. The objective of this program was:

> To determine whether, given full control of the student's time, it is possible for a hospital school to achieve the two-fold purpose of increasing the number of nurses without adversely affecting the quality of nursing.

To realize this objective the nursing department was reorganized. This permitted the separation of school from service which enabled each to fulfil its specific function. In keeping with the overall objective there followed essential adaptations within the school which included a revised and improved curriculum based on a two-year plan. This was to be followed by one year's interneship.

To maintain this program the cost had to be met by sources other than service. Financial assistance has been forthcoming from government funds and a charitable foundation. Once again the principle has been established that financial and administrative independence are essential to educational independence.

A third experimental program is in progress in Western Canada where resources are being pooled in an effort to provide a better educational program. The overall objective is not to prepare more nurses, but to prepare better ones. Individual schools have joined hands in an effort to overcome problems. This trend toward centralization or the regional approach is being demonstrated in a centralized lecture program in Saskatchewan. The program is designed to perform a particular piece of work for several schools in contrast to a central school. Each of the eight participating schools maintains its own identity. Each selects and eliminates its own students. The objectives of the program are as follows:

1. To provide sound, adequate instruction for nursing students in the basic sciences in the preclinical period.
2. To better the program of nursing education through the basic science preparation and to extend this program into the schools of nursing through the use of a travelling instructor.
3. To establish cost accounting systems for schools of nursing so that ultimately there will be comparable costs for nursing education in all schools in Saskatchewan.

All students report for the first four months of the preclinical period at one of two centres, the University of Saskatchewan, Saskatoon, or at Regina College, Regina. "The subjects taught include anatomy and physiology, microbiology, elementary pharmacology, nutrition, principles and applications of health teaching, psychology, mental health, English, preventive medicine, sociology, history of nursing, physical education and nursing science." The course in nursing arts is taught on return to the home school. The programs in the two schools follow similar lines. Assistance in planning is provided by a coordinator who supervises the two teaching programs. A travelling instructor will provide a link between the centralized program and the home schools. She will assist each in curriculum development, placing special emphasis on the clinical teaching program. The cost of the program has been met by funds from the Kellogg Foundation, the Saskatchewan Registered Nurses' Assso-ciation, and the University of Saskatchewan.

Let us now examine newer trends in methods of teaching. The group

dynamic technique is a relatively new approach in teaching-learning situations and is being practised with success in the basic nursing course in some centres in this country. A knowledge of group process needs to be fully understood to ensure effective application. Indiscriminate use of the method by instructors who lack an understanding and working knowledge of its function can result in ineffective and non-educative use of students' time.

There is a place in the basic nursing curriculum for various well known methods of teaching, as the lecture, demonstration, panel and seminar. The group discussion method has been employed in schools of nursing for some time, but all group discussions are not dynamic. The emphasis in group dynamics is upon group rather than individual performance and achievement. The group not only decides the problems to be solved, but participates in all stages of analysis, interpretation, application and evaluation of findings. For the student and teacher the unfolding of the curriculum by this method may be a very stimulating experience, but it should be realized that the method necessitates careful planning with time for thought, study and discussion. The student actually needs more knowledge and a better command of that knowledge. She must understand the techniques of group thinking and discussion. She must have some skill in self-expression. She must make definite preparation before each discussion period.

A unit for study may be suggested initially by the group or by the instructor. Examples of such a unit might be (1) the state of unconsciousness or (2) pain or (3) the state of dependency. The solving of these problems by the group would necessitate a study of such aspects as causes, signs and symptoms, possible complications, prevention, treatment and nursing problems associated with each condition. The group eventually acquires the same knowledge, but it has been accomplished by group action and participation. This approach tends to clarify knowledge and make it more meaningful. This method provides for the fulfillment of the needs of students as they arise and it makes possible a correlated and well integrated total program.

All of these foregoing experimental programs and methods of teaching demonstrate that improvement in the quality of teaching in the basic nursing curriculum is essential to ensure better preparation of the professional nurse. Excellence should be our watchword. Independent schools of nursing are needed to foster the development of the best in nursing. It is imperative. It cannot be more forcefully presented than in the words of Sir Richard Livingstone,

> A "habitual vision of greatness" is necessary not only to moral education but to all education. A teacher cannot give an adequate training in anything unless he knows and can make his pupil see, what is great and first-rate in it. How can you train a surgeon unless you show him the finest technique of surgery; or a teacher unless he knows the best methods of educational practice; or an architect, unless he is familiar with the great examples of his art? So, too, with all subjects from building to farming, from carpentry to Greek prose. Much else may enter the student's training; but there is no stimulus like seeing the best work in the subject which he studies; he will have no standards, no conception of the goal to which he painfully struggles, unless he sees the best; he will slip insensibly to lower levels of ideal and practice, unless it is continually before his mind, unless, in fact, he has the "habitual vision of greatness" to attract, direct, and inspire. In all studies and in all spheres of life, knowledge of the best is essential to success.

In conclusion it may be said that the results of these research activities are truly important because they strike at the very heart of many problems in nursing education. The influence of these programs will vary in direct proportion to the amount of effort put forth by each member of the organized profession in her attempt to implement any of the foregoing recognized principles of education which once more have been demonstrated for us.

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The Junior Counsellor Plan

MARGARET LAIDLAW

HAVE YOU HEARD of the Junior Counsellor system here at the Winnipeg General? We adopted this system some years ago and have found it one of the vital organizations of our school of nursing and thought you might be interested in hearing how it functions. The aims and objectives of such a plan are:

To aid the new student as an individual by giving her encouragement, reassurance and personalized attention.

To aid the new students as a class, by helping them to feel a part of the student body.

To aid the school in fostering school spirit and unity — a true "esprit de corps."

Of course all this does not happen without effort. As in all worthwhile projects, a considerable amount of teamwork and planning must be undertaken to insure its success and this starts long before the student arrives. The senior students are the junior counsellors and the main requisite is that each one must *want* to be a counsellor and that she is prepared to accept her responsibilities as such. The Junior Counsellors are evaluated by a committee from the faculty before they are given the privilege of assuming these duties.

A committee of students meets with the school counsellor and they decide which newcomer will be assigned to which senior. The choice of students is based on many factors. Consideration is given to mutual interests, religion and past environment. A sports enthusiast might not have much in common with a lover of classical music. As some religions affect living habits and recreational and cultural patterns, a similarity in thinking stimulates more harmony in residence living. Some students from rural areas may enjoy the companionship of a girl from the urban areas, so, here the committee tries to combine the two. This provides a convenient home in the city for the student from the country. Later on the urban student may find enjoyment in spending part of her holidays in the rural setting. Students come from a distance to enter our school — from the east or west coast as well as from other countries. Having homes in which they may spend "overnights" means a great deal to them. The committee takes all these factors into consideration when doing its planning.

Each junior counsellor has a conference with the school counsellor and is told who her preclinical student is and something about her. The initial acquaintance with one's new student is made by writing a welcoming letter or making a telephone call. An effort is made to see her before she enters the school if her home is in Winnipeg.

On registration day the junior counsellors are hostesses to the new

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students, their parents and friends at a tea. First impressions are often formed at this time and care must be taken to give both the new students and the parents the right attitude toward the school. From this day forward the new student must be made to feel a part of the school. The junior counsellor's first responsibility is to foster this feeling.

During the succeeding week there are many small get-togethers and one well planned party — usually a weiner roast, bowling party or sleigh ride. It is not the monetary showings that make a valuable junior counsellor but it is the informal "drop-ins" that really count. Soon the student is plunged into her studies and reluctantly shakes her head to an invitation with, "I've got an anatomy exam tomorrow." During these first trying months the junior counsellor can be most helpful by showing an interest and by giving an encouraging word when the studying seems tough and endless. However, for the preclinical student who is not too concerned about her studies the junior counsellor may need to remind her that too many interesting invitations may lure the student from her work — tact is necessary here since the suggestions may be taken in the wrong light.

There is an adjustment problem with most girls coming into an institution. One of the biggest adjustments is living with a large group of girls, all here for the same purpose, but not all of the same temperament. Consideration and respect for others, loyalty and sincerity of purpose, and honesty are all vital factors necessary in happy group living. To have to learn to eat, study, and retire at set times can be a nuisance to the individual, but a necessity for the group as a whole. Another major change will be a decline in her social life. With some this is very keenly felt at first, but gradually, with the help of her junior counsellor, the new student is able to see how she can plan her time so that she is still able to have some social life yet not neglect her school activities.

The social life of a school is quite active within itself. There are many sports and other events in which to participate. Here the junior counsellor can help by seeing that her preclinical student is introduced into the area in which she is most interested. Often the new student possesses a talent or particular skill — a lovely singing voice, an artistic hand or has earned a swimming badge. She should then be encouraged to join the Glee Club, or help out in making school posters. If she plays the piano, is dramatically inclined, she could be a wonderful asset at mass meeting entertainments.

The junior counsellor must always be prepared and willing to listen to her preclinical student when she has problems. These problems may require personal as well as professional advice. A quarrel with the boy friend or home worries may often cause emotional upsets and a heart-to-heart talk with an understanding person close enough to her own age is a great help. Quite often the type of counselling and advice the student needs is beyond the senior student's capacity. Then she refers the inquirer to one of the members of the faculty.

Theoretically the junior counselling plan functions for six months although the friendships may continue for years. When capping day comes no mother or father is more proud than the junior counsellor. "Capping" — that wonderful event when the preclinical student has been formally accepted into the nursing profession and into her chosen school!

We feel that by establishing such an organization we have profited and developed our school in many ways. Since the essence of any school is its students, discouraged, homesick, unhappy students do not make a particularly successful school. In the schools of nursing of the not too dim past there was usually no bond between the seniors and the student entering the school — in fact there was frequently fear and resentment on the part of the preclinical student caused by the strict demand of the seniors for proper respect to be shown them. There was apt to be little sympathy shown for the beginners' problems by the seniors. When our new system was put into practice we began a new era, our inter-student relationship became more democratic and free,

with the new student still having her respect for her seniors. When seniors and juniors have the same purpose and school loyalty there is much satisfaction gained and school spirit is improved — of course every student thinks her school is the best. In a profession such as ours we have traditions to uphold and protect just as we must endeavor to help raise the standards in practical and theoretical knowledge.

The junior counsellor system is also of immense value to the counsellor herself. It is a rewarding experience in just being needed and in feeling that we are helping someone over the rough spots we experienced not so long ago. Then, too, the responsibility of helping a junior student gives a great deal of pleasant satisfaction.

What is the future of the junior counselling system? Who can say? It is said that "the good survives the evil" and the junior counsellor system has held its own so far. I believe that it will have a future as long as it is needed and it will be needed as long as there are nursing schools that look to those who follow as well as to those who have gone before.

Ce que le Médecin Attend de l'Infirmière Professionnelle

GEORGES HÉBERT, M.D.

RÔLE DE L'ECOLE D'INFIRMIÈRES

QUELLES SONT MAINTENANT les qualités que doit prodiguer l'école d'infirmières à ses élèves. Il s'agit, bien entendu, d'une école d'infirmières sagement dirigée comme celles que nous connaissons dans la Province de Québec. Je ne flatterai personne en soulignant ici les éloges qu'on entend souvent formuler sur la formation donnée à nos infirmières des hôpitaux de langue française. Ceci dit sans aucune idée de comparaison avec nos hôpitaux de langue anglaise pour lesquels j'ai une très haute estime.

Le médecin attend de l'infirmière professionnelle toutes les qualités de coeur mentionnées antérieurement; en plus, il désire trouver en elle une collaboratrice capable de comprendre les problèmes médicaux. Cette compréhension, l'infirmière l'acquiert dans les hôpitaux où elle étudie. Loin de moi l'idée d'une infirmière qui se croirait savante: elle serait dangereuse. Ce n'est sûrement pas avec trois années d'étude de la médecine qu'une personne si intelligente soit-elle, pourrait prétendre saisir les complexités médicales. Par ailleurs, les notions générales reçues et l'observation de malades variés pendant trois ans inculquent à l'infirmière une très précieuse compréhension du malade. La jeune fille qui a suivi l'évolution d'un cardiaque, d'un pulmonaire, d'un digestif, d'un nerveux, d'une accouchée, d'un opéré, etc., devient habituée à bien observer les malades et l'aspect du malade. Elle a analysé son comportement de toutes les minutes, elle l'a vu s'améliorer, elle l'a vu s'aggraver et même mourir. Son sens d'observation s'est developpé et d'autant plus qu'elle a dû insérer ses remarques au dossier du malade.

IMPORTANCE DES NOTES D'OBSERVATION DES INFIRMIÈRES

Or lorsqu'un médecin, un interne ou une infirmière suivent l'évolution d'un malade avec l'obligation de consigner au dossier le résultat de leur observation, ils réfléchissent infiniment mieux que s'ils ne s'astreignent pas à

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cet effort. Ils savent que leurs notes pourront être contrôlées, critiquées, et même blâmées. Aussi avant d'écrire, ils pensent sérieusement. Plus ils pratiquent systématiquement cet effort de la pensée, plus ils deviennent sages, mieux ils savent observer et plus précieux ils deviennent pour le malade. Personne ne niera qu'une observation scientifique doit être rigoureusement consignée dans les moindres détails et selon l'ordre chronologique des faits. Une observation de malade doit être faite selon les mêmes principes. *Tous les détails doivent être inscrits et relatés avec une précision absolue.* Toute erreur en ce sens peut fausser la vérité et risquer de faire mal interpréter le malade par le médecin.

Si les infirmières sont des collaboratrices de médecins, si leurs observations peuvent avoir des conséquences dans l'état du malade, il est absolument nécessaire que ces observations soient scrupuleusement faites. Pour être ainsi faites il faut un entraînement adéquat, et pour ma part, je puis affirmer que si nos hôpitaux cessent d'exiger que soient inscrites au dossier les observations des infirmières, les malades risqueront d'en souffrir.

Déjà, dans plusieurs institutions ces notes ont été réduites au minimum, parfois à la seule signature de l'infirmière. On croit sauver du temps, on croit sauver de l'argent. On oublie que le malade peut en subir des conséquences sérieuses; on oublie que la formation de l'infirmière est, par le fait même, en décadence. Bientôt on ne trouvera plus de jeunes filles capables de comprendre le malade, de l'observer attentivement et de se réjouir de son amélioration comme de s'inquiéter de son aggravation. La jeune fille ne trouvera plus dans le cours d'infirmière ce qu'elle en attendait et qui constituait sa vocation. Son coeur la portait à se pencher sur des êtres malades pour les comprendre et les aider. Elle voulait trouver son bonheur dans les sacrifices consentis à son prochain souffrant. Or, de plus en plus, on l'éloigne du malade, comme résultat elle perd le feu sacré du dévouement, condition essentielle et je dirais *sine qua non*, de sa vocation. *En l'éloignant ainsi du malade on tue les vocations.*

Dans les milieux où on se plaint amèrement de la pénurie des infirmières, demandons-nous si la raison ne réside pas dans le fait qu'on a diminué l'intérêt de la profession d'infirmières. Les notes d'observation de l'infirmière l'aident indubitablement à comprendre son malade, donc à l'aimer. Ces notes permettent au médecin de mieux saisir la partie scientifique du malade et par conséquent de le mieux traiter. Malgré ces raisons d'importance capitale, il y a tout lieu de croire que cette méthode est en voie de disparition et sera bientôt chose du passé. Nous savons pourtant que *les médecins sérieux réclament à grands cris les observations détaillées.* Ils désirent qu'elles soient de mieux en mieux rédigées; ils apprécient hautement ces feuilles d'observations que certains excellents hôpitaux ont encore si sagement conservées — et Dieu en soit loué — feuilles dans lesquelles une colonne sert à inscrire l'heure où tel événement s'est produit, où tel médicament a été donné, où tel interne a appelé, où tel médecin est venu. Les médecins savent que tous ces détails sont de nature à aider le malade. Or ne l'oublions donc jamais tout ce qui se fait dans un hôpital doit être orienté vers le bien du malade. Lorsqu'une technique s'est avérée bonne, soyons attentifs avant de la modifier, et, *dans le cas des notes d'observation des infirmières, revenons, s'il en est temps encore, sur un passé glorieux.* Qu'on ne dise pas avec certains: "Ça ne vaut pas la peine de faire des notes, le médecin ne les regarde jamais." C'est faux; le médecin consciencieux les dévore souvent et s'il ne les regarde pas toujours, il sait généralement quand il doit les regarder. Sachons-le, dans de nombreux cas ces notes ont une très grande valeur du point de vue du traitement du malade, du point de vue scientifique et parfois même du point de vue légal.

Sa collaboratrice infirmière, le médecin la désire donc sage observateur il la veut assez instruite pour comprendre les points saillants d'une maladie, et assez instruite également pour ne pas prendre d'intiative coupable.

Il désire en plus une collaboratrice loyale. Ce n'est pas par prétention,

mais par désir de mieux servir le malade que le médecin sent qu'il doit être l'autorité médicale. Il faut être réaliste dans le monde et savoir que ce sont les personnes les plus qualifiées dans un domaine, qui doivent diriger. Les hommes d'affaires sont les plus aptes à comprendre et à organiser dans le domaine des affaires, personne ne le nie. Les avocats sont les personnes à consulter dans les questions d'ordre légal et les prêtres sont, à juste titre, les conseils théologiques. Chacun dans sa sphère mérite la considération qu'il s'est acquise par son travail et sa science.

En médecine, il est logique de le dire, le médecin représente l'autorité; or toute autorité vient de Dieu et à ce titre le médecin a droit à un juste respect. Aussi désire-t-il de ses collaboratrices immédiates le respect que lui confère son autorité. En général on ne peut pas dire qu'à ce point de vue les médecins aient à se plaindre.

Disons toutefois qu'il est important que cette autorité soit toujours respectée. Pour qu'elle le soit, l'école des infirmières a joué un très grand rôle et nous pouvons l'en féliciter. Il existe certaines exceptions cependant et je ne saurais les passer sous silence. Il y a des endroits, disons-le des hôpitaux, où la direction se croit l'autorité suprême par conséquent s'imagine que toute personne au service de l'institution doit être considérée comme un simple employé, dans le sens péjoratif du mot. Le médecin entre donc avec les autres dans le rouage de l'institution. Cette manière de voir les choses est évidement une déformation professionnelle.

L'administrateur en l'occurrence a oublié avec le temps qu'un hôpital est un établissement bien particulier, où les deux seuls éléments essentiels sont le malade et le médecin. Si bien qu'à un moment donné cet administrateur a fini par croire que c'était lui-même qui était en tout premier lieu la raison d'être de l'hôpital. De là à faire passer le médecin comme un être de second plan il n'y avait qu'un pas; on a même été jusqu'à dire qu'il était un invité dans l'hôpital. Cette manière de voir fausse évidemment la vérité et il faut faire soi-même partie active d'un hôpital pour savoir qu'une bonne administration hospitalière a un besoin constant des conseils judicieux des médecins même dans l'administration: et ceci se comprend car ils sont les seuls à pouvoir saisir d'une façon sûre la portée de telle ou telle mesure en vue du bien du malade.

Si une administration hospitalière quelle qu'elle soit, laïque ou religieuse, ne saisit pas ce point et si elle ne donne pas au médecin la place qui lui revient elle affaiblit l'autorité médicale et diminue sans s'en apercevoir le respect que l'infirmière doit au médecin. S'il en est ainsi, le malade en subira bientôt le contrecoup, sa confiance à lui aussi baissera et par conséquent le tort sera définitivement constitué. Il n'y a pas de bonne médecine sans la confiance du malade en son médecin, pas plus qu'il ne peut y avoir de bonne religion sans confiance dans l'autorité religieuse.

Lorsque l'infirmière a du respect pour le médecin, il lui est facile d'observer attentivement les ordonnances de ce dernier. Cette observation scrupuleuse de ses ordonnances, le médecin l'exige de l'infirmière, et c'est sagesse. Il ne faudrait jamais qu'une autorité autre que celle du médecin puisse jamais intervenir pour substituer un médicament à un autre ou même discuter hors la présence du médecin du médicament administré ou de la technique chirurgicale employée. Les infirmières — même licenciées depuis longtemps — n'ont pas la compétence pour apprécier la valeur du médicament ou du médecin. Pour ce faire, il leur faudrait avoir poursuivi les mêmes études. De plus, elles seraient bien avisées de se rappeller qu'en médecine Hyppocrate dit "oui" et Galien dit "non."

Magnifique Rôle Joué

J'arrive bientôt à la fin de mon entretien dans lequel je me suis permis certaines critiques qui j'espère seront constructives. Il ne serait pas juste à l'égard de nos écoles d'infirmières si je ne les félicitais du magnifique travail accompli depuis de nombreuses années. Si nos collaboratrices sont aussi parfaites qu'elles le sont dans la très grand majorité des cas, c'est que leurs écoles ont été à la hauteur de la

situation. Je n'oublie pas non plus que ces écoles ont dû s'adapter à un siècle des plus tourmentés au point de vue discipline et qu'elles ont réussi à maintenir la profession d'infirmières à un très haut standard. C'est ce qui nous a permis d'exiger, et d'obtenir à peu de chose près, la "Perfection" à laquelle nous faisons allusion au début de cet entretien. Pour continuer dans le même sens et pour que les jeunes filles de bonne éducation, intelligentes, dévouées et sincères continuent de s'inscrire dans les écoles d'infirmières, je crois qu'il ne faut jamais perdre de vue que les vocations se perpétueront si le cours et le travail de l'étudiante sont orientés vers le malade. Le coeur de la femme est une source intarissable de bonté et elle sera toujours prête à aider celui qui souffre; mais songeons que l'école ne doit pas chercher à en faire une technicienne aux gestes mécaniques. Donnons-lui la chance d'être près de son malade, de la connaitre assez longtemps pour pouvoir lui prodiguer des actes de réel dévouement et surtout d'apprendre de lui, ce que seul il peut lui enseigner. N'allons pas croire qu'il est sage de faire des rotations dans le service à la vitesse des étoiles filantes.

Gestes de Considération

Ajoutons une considération toute particulière pour la jeune étudiante infirmière: traitons-la avec toute la sympathie qu'elle est en droit d'attendre des hôpitaux. En tout premier lieu, une excellente alimentation; en cas de maladie, une chambre de l'hôpital, privée si possible, sinon avec une compagne et non avec une étrangère. Vous comprendrez pourquoi: l'infirmière ne pourra pas, étant malade, se dépouiller complètement de son état d'infirmière. Lorsque sa voisine se plaindra, aura besoin de soins immédiats, l'infirmière malade se sentira comme forcée de lui rendre divers petits services et ainsi sa propre maladie en sera aggravée. Elle ne pourra pas reposer complètement et ceci n'est pas juste pour elle. Si l'on veut bien réfléchir à ce que représente une bonne infirmière dans un hôpital, on n'hésitera pas à lui prodiguer toutes sortes de petites attentions, analogues à celles qu'elle-même donne sans compter aux malades. Nous voulons que les infirmières soient bonnes, dévouées et généreuses pour les malades, alors prêchons l'exemple et lorsqu'éprouvées ou épuisées elles sont à leur tour victimes d'une maladie qui nécessite leur hospitalisation, ne lésinons point et accordons-leur les soins auxquels elles ont droit.

Si j'étais administrateur d'un hôpital et que ma fille étudiante fût malade, je n'hésiterais pas à penser qu'après tous les actes de dévouement accomplis pendant son cours, il serait raisonnable qu'elle fût traitée avec beaucoup de considération. Sur ce point je crois que les médecins n'ont rien à se reprocher; j'ose espérer que les écoles d'infirmières, sont également indemnes de tout blâme et je souhaite que les bureaux d'administration puissent se louer de très grande justice.

Choix de son Médecin

Gardons sacré le choix par l'infirmière du médecin par qui elle désire se faire traiter. Je l'ai déjà dit ailleurs et je le répète, il faut que l'étudiante-infirmière puisse s'adresser quand elle est malade au médecin en qui elle a confiance. Bien des écoles d'infirmières, pour simplifier l'organisation du traitement de leurs étudiantes, leur ont imposé certains médecins désignés à cet effet. *Cette manière de procéder est inacceptable:* elle écarte un droit inaliénable et enseigne à tort une manière de procéder contre laquelle les individus libres ont toujours combattu. Rappelons-le bien haut: le droit du malade au choix de son médecin est inviolable et il doit particulièrement le demeurer dans toute institution hospitalière digne de ce nom.

Qu'on se rappelle que les infirmières sont de jeunes personnes et doivent pratiquer les sports: une piscine, des courts de tennis, etc., ne sont pas, dans le siècle où l'on vit, un luxe exagéré auquel elles n'ont pas droit. Encourageons-les à se développer dans les arts les plus variés.

Importance du Bilinguisme

Dans notre province insistons pour

qu'elles réalisent l'importance pour elles d'être bilingues parfaites. A ce propos, j'entendais dernièrement exprimer par un chirurgien reconnu l'idée de la nécessité pour nos écoles d'infirmières d'instituer un cours pratique d'anglais dont l'importance devrait être de l'ordre de deux heures d'anglais par jour; il voyait là un avantage indiscutable pour nos infirmières dont l'excellente formation serait rehaussée de la haute valeur du bilinguisme. Elles pourraient en grand nombre occuper des postes de commande, elles pourraient exercer une grande influence dans l'art du nursing et dans son développement, en dehors même de nos frontières.

Nécessité de Voyager

Aux infirmières licenciées je recommande à la suite du Dr. Wilder Penfield, neuro-chirurgien de réputation internationale la valeur indiscutable du voyage et l'expérience à prendre dans les hôpitaux de mentalité et de nationalité différentes. Les infirmières de nos hôpitaux n'ont pas à hésiter; elles seront accueillies et appréciées partout où elles travailleront. Elles feront ainsi honneur à leur école et à leur pays où elles reviendront impatiemment attendues par les médecins qui n'auront pas oublié la perfection de leurs collaboratrices dévouées et sympathiques.

Annual Meeting in Alberta

Alberta's Golden Jubilee year marked the 37th annual meeting of the A.A.R.N. when a record number of 350 nurses attended the general sessions held at Calgary, April 26-28.

Following the invocation by Rev. W. E. Harrison, greetings were brought by Mayor MacKay on behalf of the city and Dr. McCallum, speaking for the province. Miss Helen Penhale, president, reviewed the progress of nursing in Alberta in her opening address. Miss Eva Austin, president of the Student Nurses' Association of Alberta, noted the progress made by the new association during its first year of activity.

Reports of standing committees were followed with interest. The treasurer's report showed that the finances were in good shape.

Considerable discussion followed the presentation of proposed changes in the association's Bylaws. It was the consensus of the membership that the districts and chapters should study the revisions more thoroughly before a vote is taken upon them. Special interest committee structure will, therefore, not be altered for the time being.

A resolution that evolved from the Private Nursing Committee session is of commendable interest. The membership approved a motion to do away with the differential in rates for nursing neuro-psychiatric and alcoholic patients. "The private day nurses believe that they nurse patients, not diseases." The tariff will now be the same for the private nursing of all patients.

The Matrons of small hospitals, at their special session, discussed the thought provoking topic "Does the young graduate have difficulties in adjusting to the small hospitals?" Later, Miss Gertrude Hall chaired a panel discussion relating to the special nursing problems that arise in these institutions.

Other approved proposals that are of wide interest include:

A recommendation that a special program of training, comparable to that now provided for nursing aides, be planned for nursing orderlies to fit them to provide care for male patients.

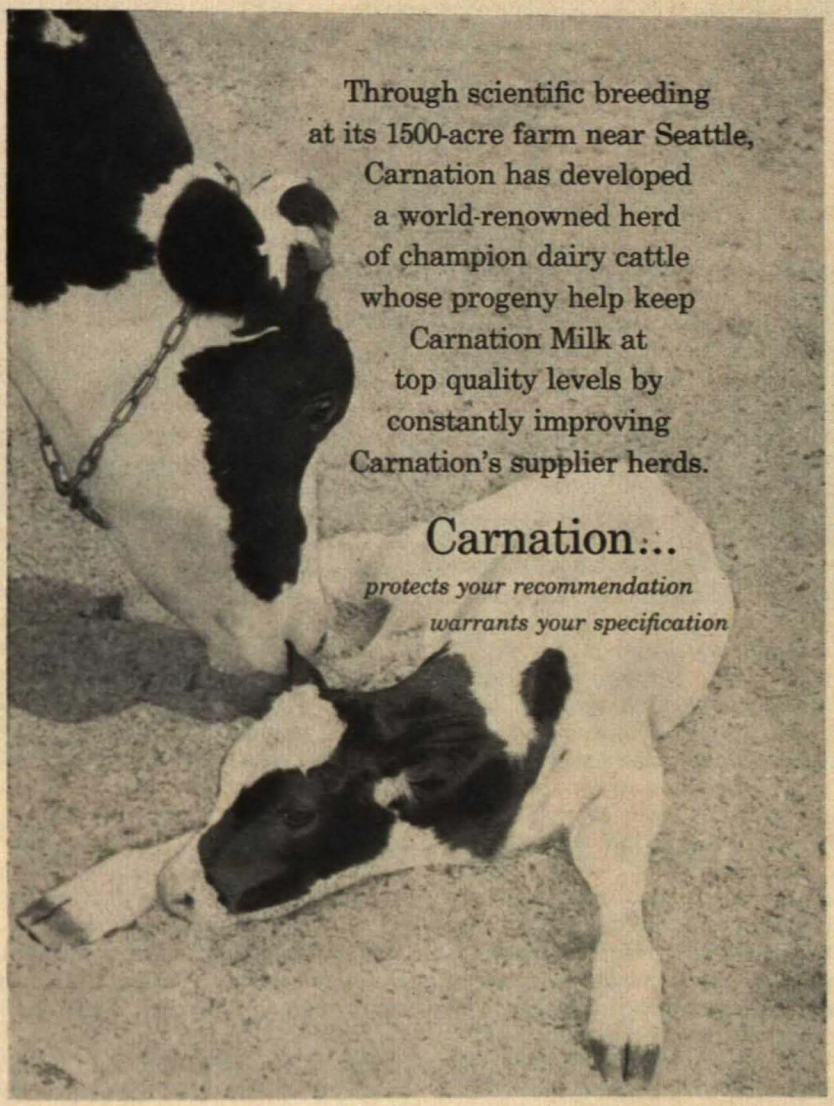
The inclusion in Personnel Policies of a clause recognizing the value of experience when initial salaries for general staff nurses are being established.

Miss Evelyn Mallory, professor and director of the School of Nursing, University of B.C., gave an interesting outline of the program of nursing education that has been developed. Alderman Grant MacEwan was guest speaker at the delightful banquet.

Miss Elizabeth Bietsch, director of nursing at Medicine Hat General Hospital, was unanimously elected to the presidency of the Association.

Clara Van Dusen
Registrar

Quand vous vous trouvez malheureux, songez aux plus malheureux que vous; la recette est infaillible.
— Madame de Maintenon



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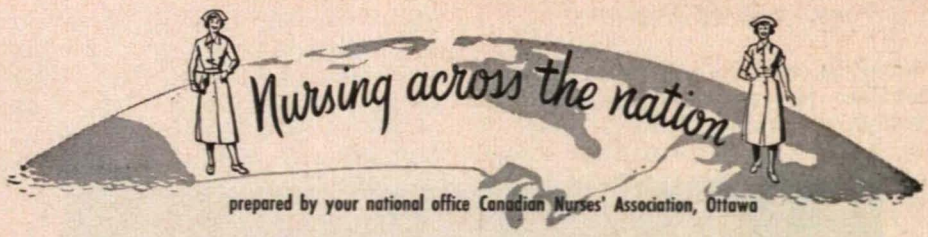


Two Park Avenue

IN AUGUST, Sister Denise Lefebvre, the chairman of a special committee of the Nursing Education Committee studying various methods of accreditation, and the CNA nursing education secretary, had the opportunity of visiting the headquarters of the National League for Nursing.

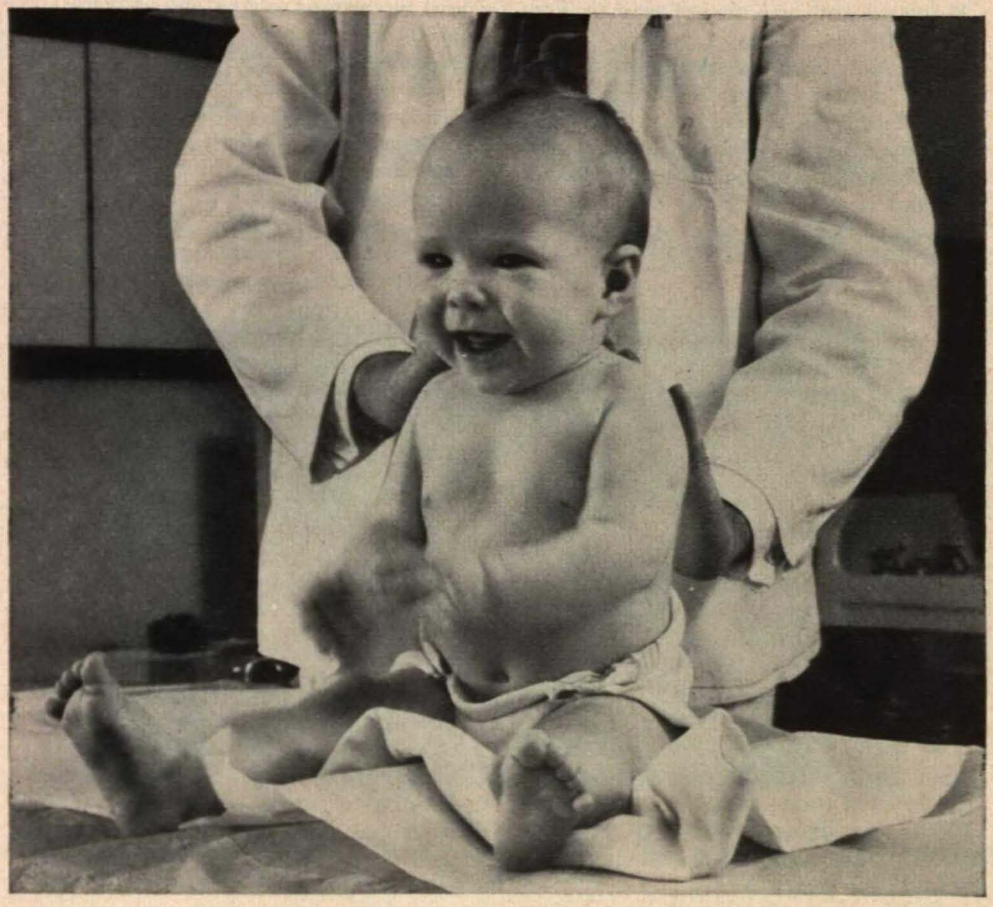
New York, of course, holds its own fascination, but to nurses "2 Park Avenue" indicates nursing on the largest scale. The NLN shares with the ANA and the *American Journal of Nursing* a floor in one of those fantastic office buildings that are so famous in New York. Our program, as arranged by Miss Helen Nahm, director of the Division of Nursing Education, allowed us to meet many of the NLN staff members who guide the varied educational programs. Accreditation of schools of nursing in the United States is now carried out by members of the NLN departments particularly concerned — the Departments of Diploma and Associate Degree Programs and of Baccalaureate and Higher Degree Programs. In this way the consultative function of the League staff can be used to its fullest extent. Of particular interest, was the one-day consultation service provided free of charge by the NLN to all schools of nursing desiring it and financed, since 1951, by grants from several foundations. It is an enormous undertaking but the effects to date have been well worthwhile in terms of improved nursing education and consequently of more effective nursing service.

Although results of NLN Test Pool Examinations, used by individual states for purposes of licensing or registration, do not influence the actual accreditation of schools, we were pleased to discuss testing programs with Mrs. Mary Shields, director of the Test Construction Unit. Four of our provincial associations are now using Test Pool papers for registered nurse examinations. The intricacies of preparing these papers so that they may be valid in all regions of the U.S.A. as well as in our four Canadian provinces, is a task that takes years rather than weeks. The preparation of Achievement Test papers, likewise, is a long process, but, as many of our schools of nursing know, they are well worth the time and effort expended. Selection and Achievement Tests in practical nursing are in preparation.

As well as visiting many departments of the NLN, we were able to convey greetings from the Canadian Nurses' Association to the American Nurses' Association. Miss Ella Best, executive secretary, was in Istanbul, Turkey, attending the meeting of the I.C.N. Board of Directors, but her deputy, Mrs. J. Whitaker, made us welcome. The International service is one of the many activities of the A.N.A. just as it is ours in Canada. Plans for nurses visiting from foreign countries are made by the A.N.A. in cooperation with state associations. Through an "Exchange" program, graduate nurses are able to practise in certain selected institutions for a limited period of time without being required to have a license. Maintenance is provided and a moderate allowance given.

A "Guy's Nurse" Visits National Office

Miss Marion Stockdale, sister tutor at Guy's Hospital, London, spent a day with us in Ottawa during October. In the course of an observation tour of schools of nursing in Canada and



"Meat....may be fed at any age"

JEAN AND MARRIOTT'S statement in 1947 in their book "Infant Nutrition" that "Meat appropriately prepared may be fed at any age" has been reinterpreted many times since in the light of clinical evidence.

Liverton & Clark (J.A.M.A. *134*,1215 (1947) show that infants of six weeks readily accept and benefit in terms of hemoglobin concentration and erythrocyte count, from a formula which increases their protein intake by 25% by the addition of Swift's Meats for Babies.

Swift's Meats for Babies are prepared from fine lean meats, specially precooked to retain their high nutritional values, and strained to a custard-like consistency. There are seven varieties, beef, veal, heart, liver, liver and bacon, pork and lamb. Swift also prepares Egg Yolks for Babies, Salmon Seafood for Babies, and Chopped Meats for Juniors.

Meats for Babies

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the United States, she had visited Montreal and was on her way to Toronto. It seems that even in Canada she kept meeting members of the Guy's medical and nursing family. This family is a very close knit one, each member of which will go out of his or her way to welcome the traveller and revel in the news of the world famous institution. As with all our international visitors, Miss Stockdale regretted that her visit was limited only to central Canada and that time did not permit her to visit farther east and west.

A Field Trip to the Maritimes

September is a beautiful month across all of Canada but perhaps nowhere is it more so than in the Maritime provinces. Our nursing service secretary, on her first visit to that part of Canada, planned to visit New Brunswick, Nova Scotia, and Prince Edward Island. Unluckily, the tail end of Hurricane Ione prevented a trip to the Island.

A visit to Fredericton and Saint John afforded an opportunity to visit the Association office of the New Brunswick Association of Registered Nurses and to meet some of the members of the executive.

Halifax turned on its finest weather and then, for a bit of variety, became stormy and foggy. But the spirit and enthusiasm of the nurses was not dampened by the weather. Here the Nova Scotia Association of Registered Nurses' office, Dalhousie University and other institutions were visited.

The nursing problems discussed in both provinces, during visits to hospitals and agencies, were similar to those elsewhere in Canada:

Lack of well prepared staff, especially in the teaching and administrative areas; the need of nurses for preparation as team leaders and for satisfactory experience in team nursing.

The delegation of non-nursing functions by nursing service administrators in small hospitals to other personnel; student nurses carrying too heavy a proportion of nursing service, especially on night duty.

The need for better understanding and closer cooperation between nursing service and hospital administration; the need to stimulate interest and participation of all nurses in their professional associations.

The importance of nurses being active in hospital planning and in the selection of equipment as it affects nursing; the importance of and need for continuing in service education.

All of these problems were not, of course, evident in all hospitals and agencies visited. Some had found satisfactory solutions or were working together in seeking solutions.

It was a disappointment to miss the long anticipated visit to P.E.I. Perhaps before too long, another opportunity will present itself to meet and discuss nursing service with the Island nurses.

The warm friendliness and gracious hospitality so evident everywhere, made this field trip a truly happy experience.

For All the World's Children

Recently a meeting was held in Toronto of the newly-formed Canadian UNICEF Committee, at which a representative of the CNA was present. The United Nations Children's Fund is the world's largest international effort to improve the health and welfare of children and mothers. From an emergency organization set up in 1946 to meet the needs of children in war-torn countries, it has developed into an essential part of the United Nation's effort to raise the standards of life in economically underdeveloped countries.

There are some 28 national committees in a good many parts of the world. UNICEF works very closely with WHO in carrying on its program, which is to:

Help fight disease.

Combat malnutrition.

Encourage basic health care.

Give emergency aid.

Mrs. D. B. Sinclair, executive assistant to the Deputy Minister of Welfare, who is our delegate to UNICEF, stated that Canada has contributed $500,000 in the last five years.

This help given "for all the world's children" is something that all Canadians and particularly we nurses, who

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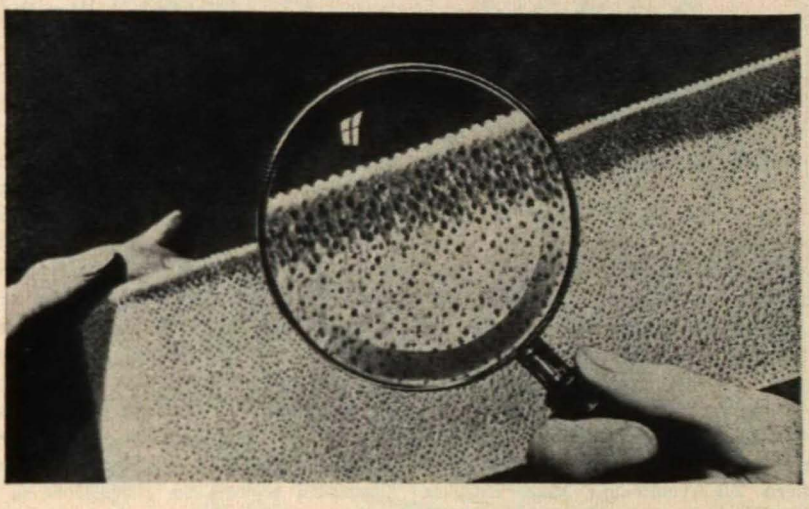

SMITH & NEPHEW announce that a new form of Elastoplast — a bandage with a Porous Adhesive spread — is now available. After years of extensive clinical trials and successful use in Great Britain, results confirm that this new Porous adhesive largely overcomes skin reaction to occlusion, which some patients experience beneath fully spread adhesive bandages, by permitting free evaporation of sweat and minimizing epidermal keratinisation produced by the stimulating effect of the adhesive.

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assist with care of the children of our land, would wish to support.

One of the ways we can help in this Christmas Season is to purchase UNICEF Greeting Cards, which may be obtained from the United Nations Association in Canada, 340 McLeod Street, Ottawa, Ont.

Calling All Japanese Nurses

At regular intervals we receive the *Japanese Nurses' Journal* in National Office. Reading the enclosed English index, we wish we were more conversant with Japanese. Are there any nurses reading this column who can read Japanese? If so, let us know where you are. We shall be glad to send on these interesting booklets.

Season's Greetings — Very Best Wishes for this Holiday Season from your National Office staff.

Le Nursing à travers le pays

Deux, Avenue du Parc

Au mois d'août, Soeur Denise Lefebvre, la convocatrice d'un comité spécial formé pour étudier les diverses méthodes de certification, et la secrétaire du comité de l'éducation de l'A.I.C., avaient l'avantage de visiter les quartiers généraux de la National League for Nursing (ligue nationale américaine du nursing).

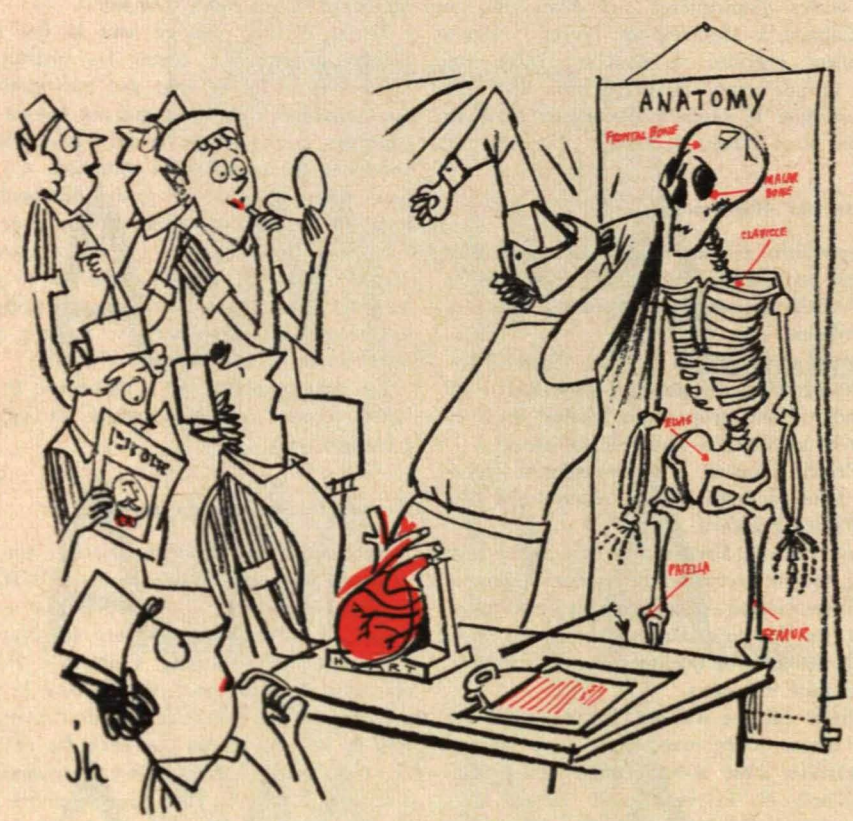
New-York, naturellement, a toujours son charme particulier mais, pour les infirmières, le numéro 2, Avenue du Parc, c'est le nursing dans toute son envergure. La NLN se partage avec l'ANA (American Nurses' Association) et l'*American Journal of Nursing* tout un étage de l'un de ces gigantesques édifices que l'on voit à New-York. Le programme que nous avait tracé Mlle Helen Nahm, directrice de la Division de l'Education, nous a permis de rencontrer plusieurs membres du personnel de la NLN chargés des divers programmes éducatifs. La certification des écoles d'infirmières aux Etats-Unis est maintenant confiée à la National League for Nursing dont les fonctions consultatives sont largement mises à la disposition de tous les intéressés. Une innovation d'un intérêt particulier fut l'offre, à titre gracieux, des services d'une consultante, pendant une journée, à chaque école qui désirerait en profiter; cette initiative fut rendue possible grâce à des octrois provenant de diverses fondations. Ce fut là une entreprise colossale dont les résultats se sont démontrés plus que satisfaisants en matière d'éducation en nursing dont les progrès constants ont une heureuse influence sur l'efficacité des services du nursing.

Bien que les résultats du système d'examens en communs (Test Pool) de la NLN, utilisé dans plusieurs états pour fins d'enregistrement ou de licence, n'influe aucunement sur le mode actuel de certification des écoles d'infirmières, nous avons trouvé bien intéressant de discuter de cette question avec Mme Mary Shield, chargée de cette division. Quatre de nos associations provinciales utilisent maintenant les examens communs (Test Pool) pour l'enregistrement de leurs infirmières. Il va sans dire que la préparation des questions d'examens est complexe; il faut qu'elles conviennent à toutes les régions des Etats-Unis de même qu'à quatre de nos provinces canadiennes; c'est là une tâche qui prend des années plutôt que des semaines, à mettre au point.

Tout en visitant les nombreux départements de la NLN, nous avons eu l'occasion d'offrir les hommages de l'Association des Infirmières Canadiennes à l'Association des Infirmières Américaines. Mlle Ella Best, la secrétaire-registraire était absente; elle était en Turquie où elle assistait à la réunion du Bureau de Direction du Conseil International des Infirmières mais son adjointe. Mme J. Whitaker nous a souhaité la bienvenue. Le service international constitue l'une des nombreuses activités de l'ANA tout comme pour nous au Canada. Grâce à un programme d'échange, des infirmières d'autres pays peuvent exercer la profession dans certaines institutions choisies à cette fin, pendant un certain temps sans être obligées de s'enregistrer. On leur accorde une allocation moyenne en plus de leur entretien.

En visite chez nous

Nous avons reçu, au bureau national à Ottawa, la visite de Mlle Marion Stockdale



The Educational Director

Transforming a group of eager but unskilled girls into a class of competent professional nurses is no easy assignment—but that's the task of the Educational Director. The high quality of today's nursing is evidence of her excellent instruction, patience, discipline, and hard work. It is difficult to overestimate her contribution to medicine.

To help this busy executive, Lederle provides a number of materials and services designed to keep both student and graduate nurses informed on the newest drugs. There are films, exhibits, booklets, and other printed matter. The Lederle Representative himself will gladly talk to such a group at any convenient time.

To learn more about these helpful, worthwhile teaching aids, contact the Lederle man through your hospital pharmacist!

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MEDICAL REPRESENTATIVE

du Guy's Hospital de Londres; elle a passé une journée avec nous en octobre. Au cours de son voyage d'observation elle a visité des écoles d'infirmières aux Etats-Unis et au Canada à Montréal et Toronto; elle a vivement regretté ne pouvoir visiter une plus grande partie de notre pays dont elle n'a vu que le centre; elle aurait aimé en visiter aussi l'ouest et l'est.

Visite aux Maritimes

Septembre est un mois magnifique dans toutes les parties du Canada mais je ne crois qu'il puisse être surpassé dans les Maritimes.

Notre secrétaire du Service d'Infirmières, à son premier voyage dans cette partie du Canada s'était proposé de visiter le Nouveau-Brunswick, la Nouvelle-Ecosse et l'Ile du Prince-Edouard. Malheureusement l'ouragan Ione l'a empêchée de se rendre à l'Ile du Prince Edouard.

Une visite à Fredericton et à Saint-Jean lui a fourni l'occasion de visiter le bureau de l'Association des Infirmières Enregistrées du Nouveau-Brunswick et de faire la connaissance de quelques-uns des membres du Comité Exécutif.

Halifax lui est d'abord apparue sous ses plus beaux jours mais, pour faire un peu de variété, s'est soudainement voilée d'un brouillard et le vent s'est élevé. Mais l'humeur et l'enthousiasme des infirmières n'en furent pas pour cela abattus. Ici elle eut l'avantage de visiter le bureau de l'Association des Infirmières enregistrées de la Nouvelle-Ecosse, l'Université Dalhousie, ainsi que d'autres institutions.

Les problèmes du nursing discutés dans ces deux provinces en visitant les hôpitaux et autres organismes de santé se sont avérés à peu près les mêmes que dans les autres parties du Canada: Insuffisance de personnel bien préparé, particulièrement dans les domaines de l'enseignement et de l'administration; le besoin d'infirmières possédant des qualités de chefs et ayant l'expérience nécessaire pour le travail d'équipe. La transmission par les autorités du service de nursing de tâches non-professionnelles à d'autres membres du personnel; les élèves infirmières ont une trop grande proportion du service du nursing à exécuter, particulièrement en service de nuit; le besoin d'une meilleure compréhension et d'une coopération plus étroite entre le service du nursing et l'administration de l'hôpital.

L'importance d'associer les infirmières à l'organisation hospitalière et au choix de l'équipement dont on se sert en nursing; l'importance et la nécessité de continuer la formation en cours d'emploi.

Il est entendu que ce sont là des problèmes généraux à toutes les institutions visitées et qu'ils ne sont pas tous présents dans chacune; il y en a qui ont trouvé des solutions satisfaisantes ou qui s'efforcent de travailler à améliorer la situation. Ce fut pour notre visiteuse un grand désappointement de ne pouvoir aller tel que prévu à l'Ile du Prince-Edouard où elle se proposait de faire une longue visite. Il se peut qu'avant longtemps l'occasion se présente de discuter des problèmes du nursing avec les infirmières de l'Ile.

La franche amitié et la gracieuse hospitalité reçues partout a rendu ce voyage très agréable.

A tous les enfants du monde

Récemment, fut tenue à Toronto une réunion du nouveau comité canadien UNICEF à laquelle assistait une représentante de l'A.I.C. Le Fonds des Enfants des Nations Unies (United Nations Children's Fund) constitue le mouvement international le plus considérable au monde en vue de l'amélioration de la santé et du bien-être des enfants et des mères. Née d'une organisation d'urgence établie en 1946 pour répondre aux besoins pressants des enfants des pays dévastés par la guerre, cette initiative est devenue une partie essentielle de l'effort tenté par les Nations Unies pour relever le niveau de vie dans les pays non suffisament développés au point de vue économique.

Il y a 28 comités nationaux de par le monde. L'UNICEF travaille en étroite collaboration avec l'OMS dans l'exécution de son programme qui est de:

1. Aider à combattre la maladie.
2. Lutter contre une nutrition défectueuse.
3. Favoriser les soins sanitaires de base.
4. Apporter les secours urgents.

Mme D. B. Sinclair, assistante du sous-ministre du Bien-Etre, déléguée du Canada à l'UNICEF, affirme que la Canada a contribué pour une somme de $500,000, au cours des quatre ou cinq dernières années.

Cette aide, apportée à "tous les enfants du monde" est une oeuvre que tous les canadiens et nous, particulièrement, infirmières devrions avoir à coeur de maintenir.

L'un des moyens par lesquels nous pouvons contribuer à cette oeuvre humanitaire, serait en ce temps de Noël d'acheter des

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cartes de souhaits de l'UNICEF que l'on peut obtenir de l'Association des Nations Unies au Canada, à 340 rue McLeod, Ottawa,, Ont.

Nous sommes heureuses d'offrir nos meilleurs voeux de Noël et de Bonne Année à tous les membres de L'Association des Infirmières Canadiennes.

Sélection

L'évolution de notre conception des soins infirmiers

Par M. le Docteur Boidé, Directeur de l'Hygiène publique et des Hôpitaux au Ministère de la Santé Publique et de la Population, Paris, France.

Les progrès scientifiques réalisés au cours de ces dernières décades, principalement ceux qui appartiennent à la médecine et à la chirurgie, sont largement diffusés et commentés par tous les publics, même les moins avertis. Les bouleversements qu'ils entraînent dans la prévention et le traitement des maladies, sont également connus tout au moins dans leurs grandes lignes.

Mais ce que l'on ignore encore trop souvent, c'est la multiplicité des problèmes que ces bouleversements posent à l'homme et à la société. Ces problèmes, qu'il appartient aux pouvoirs publics comme aux individus, de résoudre, comportent des facteurs financiers, économiques, sociaux et aussi, et surtout, des facteurs humains.

J'aimerais attirer l'attention des infirmières sur certains de ces problèmes car elles ont à jouer dans leurs solutions, un rôle extrêmement important, et qu'elles n'y sont pas toujours préparées.

Je voudrais, tout d'abord, insister sur les réactions du malade devant la médecine scientifique actuelle. Les thérapeutiques qu'elle entraîne sont dans la majorité des cas plus actives, mais aussi plus dangereuses; l'innocuité des traitements exige une posologie précise qui nécessite des examens biologiques nombreux. Leur mise en oeuvre repose sur des techniques délicates, complexes, choquantes parfois. Leur surveillance entraîne enfin des examens physiques, chimiques et biologiques répétés fréquemment et minutieusement notés. Le contact Médecin-Malade qui est infiniment plus efficace que par le passé, développe une contrepartie regrettable: le malade a de plus en plus tendance à perdre son caractère d'homme pour ne devenir aux yeux du médecin et de ses collaborateurs qu'un "dossier." L'infirmière d'aujourd'hui qui doit être une excellente technicienne, instruite et parfaitement au courant de l'application et de la surveillance de ces thérapeutiques, doit également connaître ce danger, et doubler le médecin dans ce rôle humain; sinon des désordres affectifs graves, d'inadaptation, de défiance et de crainte peuvent se développer chez le malade, entravant sa participation active à la guérison.

Nos esprits latins veulent comprendre et nos malades admettent difficilement qu'on leur impose des thérapeutiques compliquées et des règles de vie qui leur semblent draconiennes si on ne leur a pas expliqué le bien-fondé de ces ordonnances. Ces explications, les médecins les doivent et les donnent, mais souvent brièvement, ou en les faisant parfois volontairement imprécises, si bien que les malades demeurent avec leur inquiétude et de leur insatisfaction. Il faut que les infirmières connaissent ces problèmes et en comprennent la gravité; il faut qu'à l'hôpital, au dispensaire ou à domicile, elles soient capables de déceler les réactions psychiques de leur malade et d'intervenir au moment opportun pour empêcher que des complexes s'établissent et viennent entraver la guérison; il faut qu'elles n'oublient jamais qu'une partie essentielle de leur rôle est justement d'humaniser ces contacts et d'adapter personnellement à chaque malade les règles scientifiques de la médecine actuelle. Ayant le privilège de voir vivre plus intimement le malade, de le connaître, donc de le comprendre mieux, elles peuvent nuancer leur comportement suivant les besoins de chacun, et par leur influence, créer une atmosphère de détente et de sympathie aussi nécessaire aux êtres que le confort et les soins d'hygiène. Leurs études doivent leur permettre d'acquérir cette compréhension intelligente et sympathique des comportements humains. Des notions de psychologie et de psychiatrie doivent leur être données de telle façon qu'elles puissent baser leur conduite et leur action sur les principes essentiels qui s'en dégagent.

Les réactions de l'individu devant les règles de la médecine préventive ne sont pas

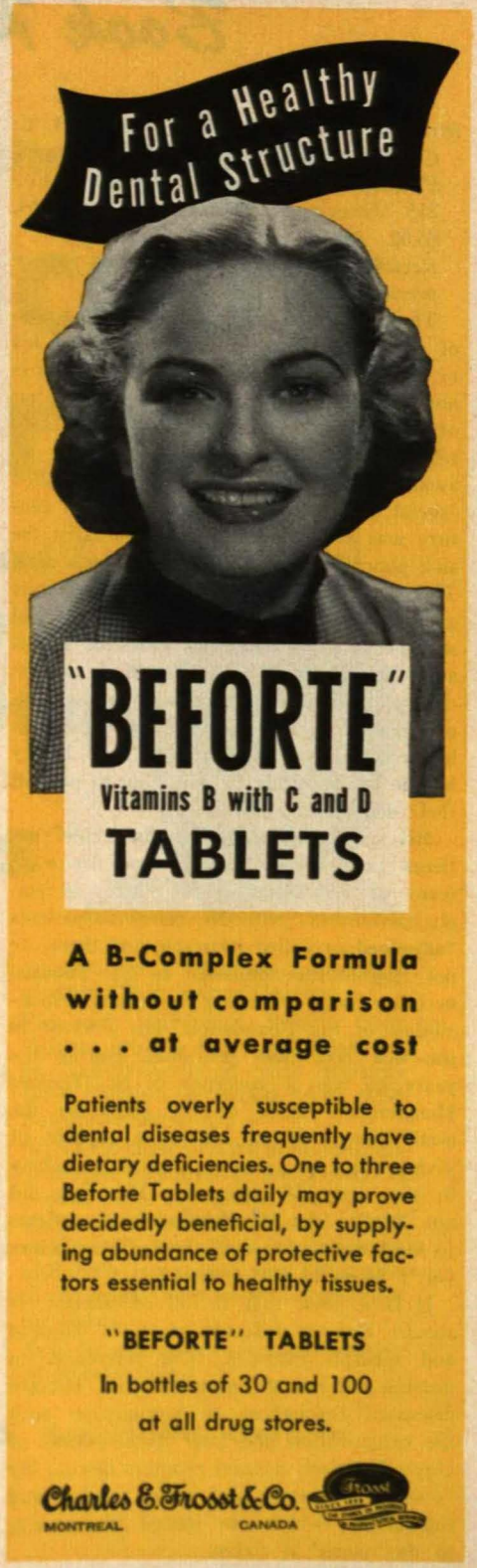
moins violentes; qu'elles soient du domaine de la médecine (vaccinations obligatoires, visites systématiques, etc.) ou d'hygiène (règlements sanitaires, problèmes d'assainissement du milieu) les lois et les règlements que la société élabore risquent d'apparaître à ceux qui les comprennent mal comme une manifestation d'étatisme. L'individu se sent alors frustré de ses droits les plus stricts vis-à-vis de lui-même, de ses enfants, de sa famille. Là encore, l'infirmière doit intervenir: à côté et avec le médecin et l'assistante sociale, elle doit démontrer le bien-fondé de notre législation, en faire comprendre l'esprit.

Quittant l'individu, je voudrais maintenant insister sur quelques autres problèmes qui sont nés des découvertes actuelles des sciences exactes, comme des sciences humaines et sociales. Ces découvertes ont orienté les esprits des médecins comme des pouvoirs publics, vers une compréhension plus générale des besoins des hommes et vers une connaissance plus nuancée de leurs réactions physiques et psychiques. La tendance générale de la médecine actuelle est l'acceptation d'une conception beaucoup plus large de sa responsabilité. Le dispensaire et l'hôpital ne sont plus maintenant de simples centres de dépistage et de soins; ils prennent de plus en plus — et cette évolution ne fera que s'accentuer dans l'avenir — le caractère de centres de santé ou la Médecine préventive ne doit plus être dissociée de la Médecine de soins, où la réadaptation physique, psychique et sociale du malade est minutieusement prévue et où l'éducation du malade prend une place prépondérante.

En même temps que les sciences médicales progressent, il faut que l'infirmière élargisse sa conception des "soins infirmiers" et demeure la collaboratrice étroite du médecin dans ces domaines de prévention, de rééducation et d'éducation qui étaient réservés jusqu'à ce jour à des spécialistes de médecine préventive et de médecine sociale.

Aussi donc, à côté de connaissances techniques infiniment plus profondes et plus vastes que par le passé, où la physiologie et la psychiatrie ont leur place comme certains éléments de sociologie et de statistiques, c'est un faisceau élargi de méthodes de travail que l'infirmière d'aujourd'hui doit posséder.

Extrait de la *Revue de L'Infirmière et de l'Assistante Sociale* (Paris) numéro de juin 1955.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MONTREAL
CANADA

Book Reviews

Mr. Guy's Hospital, 1726-1948 by H. C. Cameron, M.D., F.R.C.S. 520 pages. Published by Longmans, Green & Co., 215 Victoria St., Toronto 1, Ont. 1954. $6.00.

Reviewed by Miss Grace Fairley, former president of CNA.

The title is at once fascinating, for who of the hospital world has not created his or her own picture of "Guy's?" This book is not only a history of Guy's Hospital, but of the City of London, and the early schools of medicine. It also discusses an awakening of what today would be called "social service", but in the early 18th century was known as "charities" to assist the sick poor, lame aged citizens and prisoners. This last group had evidently a definite appeal to Mr. Guy. Copies of his financial statements show numerous cases of assistance having been given by him to discharged prisoners (especially those imprisoned for debt). By 1839, more than six hundred persons had regained their liberty by the grants made by Mr. Guy to pay off their debts.

His special sympathy for "incurable" patients (really convalescent) and for some form of rehabilitation for them, is emphasized in his will. He refers to patients "adjudged or called incurable and therefore not eligible for admission to St. Thomas' or other hospitals" being the special responsibility of his Foundation. His interest in the sick poor was profound. During the years he was a governor of St. Thomas Hospital, he made definite plans for the establishment of an institution capable of giving the type of care so greatly lacking in the early 18th century. Mr. Guy did not live to see the admission of patients to his hospital. He died about a year before Guy's Hospital was opened.

It is a book that is full of interest. It should find a welcome place in hospital and medical libraries. The references to nursing are not given in sequence, but are discussed throughout in conjunction with the organization and later developments of Guy's Hospital. Several chapters discuss the "old-time" nurse, her salary, rules and regulations, which are indeed illuminating to the reader of today.

The establishment of the school of nursing in 1880 and what is referred to as "the Great Nursing Dispute" are given much prominence. At that time the introduction of lady-pupils took place while some of the old practical nurses were still on the staff. The matron had to face great opposition from the medical staff but she had the support of the treasurer (senior administrator) and governors. They issued a printed ultimatum, the first clause of which was "That it is essential for the well being of the hospital that the medical staff and the nursing department should work in harmony." From then on, the steady development of the school and its great contribution to nursing is well told in the succeeding chapters.

Many world-famous names appear in the lists of medical and surgical staff, boards of governors, and matrons during the two hundred years of this history. In 1895, when the hospital was in financial straits, the Prince of Wales became president and chaired a banquet for the purpose of raising funds. He was encouraged to take the presidency by Mr. Fripp (surgeon to the Royal household). Among the governors at that time were Mr. W. E. Gladstone and Mr. Arthur Balfour — both of whom held the office of Prime Minister of Great Britain.

The book is likely to appeal to the average reader as an outstanding saga of hospitals, medical science and nursing, with a fine demonstration of love and charity during a rapidly changing era.

The Story of Medicine, by Arthur L. Murphy, 243 pages. The Ryerson Press, 299 Queen St. W., Toronto 2, Ont. 1954. Price $3.50.

Reviewed by Sister St. Albert, St. Joseph's Hospital, Toronto, Ont.

The author strides buoyantly up the hill into "the temple of medicine." He pushes the door open and with confident step makes his way unerringly towards "the tall, unfinished tower of surgery." Up he climbs with unfaltering step for twenty years, using all the many scientific facilities available to medicine of this era. Then he pauses in his ascent, gazing back with appreciation over the centuries. He allows his mind to take him back to ancient times — about

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which little accurate information is to be had. He travels fairly rapidly through the centuries, touching the highlights of the scientific development of medicine down to the present time. In spite of this rather rapid survey he gives us an interesting and stimulating picture of the men of science. Some were not primarily interested in medicine but their work made possible certain developments.

It is an interesting and enjoyable book. As one reads one can sense the respect and sympathetic understanding of the author for these predecessors of his who lived in other times, but who are one with him in spirit. Student nurses, high school students and university students will find "The Story of Medicine" both fascinating and informative. Instructors of history of nursing and vocational directors in high schools will find it extremely helpful in the teaching and direction of students.

The Improvement of Patient Care, a study at Harper Hospital, by Marion J. Wright, R.N., M.S. 236 pages. McAinsh and Co., Ltd., 1251 Yonge St., Toronto 5, Ont. 1953. Price $5.50.

Reviewed by Phyllis L. Barrett, Director of Nursing, St. John's General Hospital, St. John's, Newfoundland.

This is a comprehensive study, the goal of which is constantly in the foreground — improvement of patient care, based on the view that each individual comprising the hospital staff contributes to that care. Any study with this goal should be of paramount interest to all administrators as it contains vital implications for all who have a part in hospital management. Harper Hospital in Detroit faced a task of increasing its bed capacity, and at the same time maintaining the existing facilities in face of the diminishing supply of personnel. Under Miss Wright's direction, a study of Harper and three other cooperating hospitals was undertaken to determine the existing problem.

A measure of practical worth was achieved as a result of the enormous amount of time, energy and talent expended by so many people. By utilizing the special knowledge and skills of authorities drawn from the areas of industry and business, job description, work simplification, and ratio-delay studies were made possible. The study provided a medium (surveys, questionnaires, etc.) for the individual to express his opinion and offer suggestions pointing toward improved patient care.

All the component parts of care provided for patients, as well as staff activities and functions were critically evaluated. Questionnaires were sent to 48 hospitals. It was very interesting to compare the returns and to note the variations in the classifications of the many duties involved in giving care. A thorough study of all levels of nursing care was done. A conception of group nursing evolved emphasizing leadership, orientation, and inservice education. Here time studies and job analyses were used effectively.

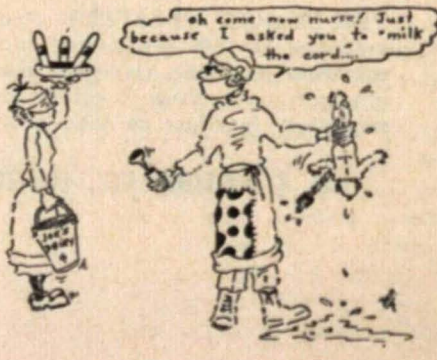
"Improvements are always possible to those who are open-minded enough to want to make them . . . We seem to have found a positive point of view." These quotations should haunt administrators who are interested in the improvement of patient care. The practical thoroughness of the study should serve as an incentive to those who are facing similar problems. "Probably the greatest value lies in the Appendix material as it shows that methodology for a study of this sort had to be built from the ground up." Miss Wright, the administrator and trustees of Harper Hospital have offered a wealth of knowledge. They have presented factual evidence that utilizing manpower more efficaciously helped them to reach their objective.

This study should stimulate planning for the most effective use of nursing resources in the interest of the patient. We, as nurses, see the great need to continue a study such as this, and to utilize the same basic principles in every department of the hospital.

* * *

There is more radio active iodine used today as "medicine" than all other radioactive isotopes combined. Through it the serious heart disease caused by the thyroid gland's over-activity is now regarded as one of the most curable of heart disorders.

—I.S.P.S.



Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

Appointments — *Christine MacLeod* (McKellar Gen. Hosp., Univ. of Toronto) to Fort William and District Health Unit; *Gladys (Bowman) Franchetto,* (St. Mary's Hosp., Kitchener, Univ. of Western Ont.) to Guelph Board of Health; *Edith Holub* (Toronto Western Hosp., U. of W.O.) to the Kingston B. of H. *Angela Psutka* (St. Mary's Hosp., Kitchener, U. of T.) from Huron County H.U. to Kitchener B. of H. *Olga Wallace* (Hamilton Gen. Hosp., U. of W.O.) to Leeds and Grenville H.U. *Mary Willsher* (St. Michael's Hosp., Toronto, Univ. of McGill) to Lennox and Addington H.U. *Madeline Lynes* (St. Joseph's Hosp., Guelph, U. of W.O.) and *Doris (Kirkwood) Burnes* (Cornwall Gen. Hosp., U. of W.O.) to Middlesex County School Health Service. *Jessie Renton* (Stobhill Hosp., Glasgow, U. of T.) from the Lennox and Addington H.U. to Sault Ste. Marie B. of H. *Jean Guild* (Toronto Gen. Hosp., U. of T.) and *Blanche Gordon* (Toronto West. Hosp., U. of T.) to Scarborough B. of H. *Myra (Walker) Chalmers* (Greater Niagara Gen. Hosp., U. of T.) formerly with the Welland and District H.U.; *Margaret Coyne* (St. Jos. Hosp., Toronto, U. of To.) formerly with Porcupine H.U.; *Eleanor (Leavens) Jackson* (Women's College Hosp., U. of W.O.) formerly with the Toronto Dept. of Public Health; and *Jessie Yule* (T.G.H., U. of T.) all to Simcoe County H. U. *Jean (Plewes) Bourne* (H. G.H., U. of W.O.) formerly with Hamilton Dept. of Health to Toronto Dept. of Public Health. *Noreen Heath* (Royal Southern Hosp., Liverpool, Univ. of Pennsylvania) formerly with Hamilton Dept. of Health to Windsor Dept. of Health. *Margaret Baillieul* (Glace Bay Gen. Hosp., U. of T.) to York County H.U. *Geraldine Graham* (St. Michael's Hosp., Toronto, U. of T.) formerly with Guelph B. of H. and *Lois (Galpin) Percy* (B.Sc.N., U. of W.O.) formerly with Peterborough B. of H. to York Township B. of H.

Resignations — *Mary (McVicker) Pippy* from Kingston B. of H. *Mary Fenton* from Ottawa B. of H.; *Mary MacIlveen* B.S., from the position of supervisor, Peterborough; *Elsie (Ranney) Fookes* from Scarborough Township B. of H.

L'ennui est entré dans le monde par la paresse. — LA BRUYÈRE

News Notes

ALBERTA

DISTRICT 7

EDMONTON

At the September meeting of the district there were twenty-six members present. Miss Lea gave the program report. It was decided to write Mrs. Van Dusen to express appreciation of her work and that of her staff in the publication of the A.A.R.N. periodical. Miss Reeves showed slides from the Ernest Brown collection on early Alberta.

BRITISH COLUMBIA

FORT GEORGE

At the first meeting of the chapter plans for raising money to assist a high school student to enter nurses training next year were launched. This is the big project of

the year. Mr. Thomson, guest speaker, outlined the progress made towards forming a hospital improvement district and also gave a résumé of the recent work done by the Civil Defence Organization. A bursary tea was held in October. Miss C. Charter, assistant director of nurses for the Victorian Order of Nurses, Vancouver branch, conducted an institute on body mechanics the first week in October.

Trail

The October meeting was held in the Nurses' Residence. Twenty-two members were present. Mrs. Ross, the president, conducted the meeting and gave an explanation of the R.N.A.B.C. structure. Lectures in Body Mechanics and Rehabilitation Nursing Institutes have commenced in Nelson. Polio vaccine is now part of the regular immunization program. Mrs. McGerrigle volunteered to look after the library during the winter months. Mrs. Ferguson gave a very informative talk on the duties of the V.O.N. and Dr. Love a most interesting talk on B.C.H.I.S. and the problems of the Trail-Tadanac Hospital.

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NEW BRUNSWICK

Moncton

The monthly meeting of the chapter was convened by the president, Miss H. Hayes. Reports were given by Mmes: L. Coldwell, D. Van Breskirk, S. Richardson, E. Stone and H. Smith.

It was planned that the Ladies Guild of St. Andrews Church would cater for a tea during the N.B.A.R.N. convention. The banquet was to be held at the Brunswick Hotel with John Fisher, well known radio commentator as guest speaker. Members of the executive of the N.B.A.R.N. were entertained at a dinner by the chapter.

Dr. R. D. Landry gave an interesting talk on polio vaccine. Refreshments were

served by Mmes: K. Carroll, B. Smith and Misses S. McLoed, R. MacKenzie.

Nurses' Hospital Aid

Mrs. Ken Mayhew, president, conducted the monthly meeting of the Aid. Plans for a cooking sale with Mrs. C. McKie as convener were reviewed. Ways and means of raising money were discussed. The mystery box was won by Mrs. S. Dunham. Hostesses for the evening were: Mmes. K. Carroll, F. B. Robinson, C. Colwell and Miss K. Richardson.

ONTARIO

DISTRICT 5

TORONTO

Women's College Hospital

The first meeting of the fall was held in September. Mr. Hassing, from Henry Birks, spoke on the making of fine china and crystal in England and Denmark, showing colored slides. Miss C. Dixon, the first nurse to join the staff is retiring after 39 years. She was honored at a buffet supper and presentation by the Board of Governors. The alumnae sponsored a "Theatre Night" in October. This is their big money-making project of the year for their scholarships and loan fund. The hospital auxiliary held a tea, also a home baking and gift sale in October. V. Treacy has left for overseas duty in Germany. L. Bernache is assistant on fifth floor. W. Sims has enrolled at Teacher's College, Columbia University. E. Wiltshire has taken the position of school nurse at Seller Institute in Grande Ligne, Que. K. Mullen is stationed at Burns Lake, B.C.

QUEBEC

MONTREAL

Montreal General Hospital

A tea was held in honor of Miss Denovan who has retired from the night staff. A. Beverley has received her degree of Master of Public Health from Yale University and has returned to McGill University as associate professor of the School for Graduate Nurses. M. Wheeler has been appointed industrial nursing consultant for the province of Quebec. I. Riley has received her degree of Bachelor of Nursing from Columbia University and is now on the Teaching Staff of the Jewish General Hospital. C. McMillan, Mmes. N. Mills, H. Fuller, F. (McDougall) Robinson have all joined the teaching staff. E. Gilbert is attending McMaster University in Hamilton. A. Tyler is leaving to nurse in Pakistan. C. Legge has left for England where she plans to work in one of the large hospitals in London.

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The Johns Hopkins Hospital
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(4) 522 Dominion Public Building, Winnipeg, Manitoba;
(5) Box 292, North Bay, Ontario;
(6) 55 "B" St. Joseph Street, Quebec, P.Q.;
(7) Moose Factory Indian Hospital, Moosonee, Ontario.

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Chief, Personnel Division,
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Supervisor of Public Health Nursing for generalized program in city of 43,000. 5-day wk., 1 mo. vacation with extra time at Christmas or Easter. Cumulative sick leave. Pension plan, Blue Cross & P.S.I., Workmen's Compensation. Transportation provided or allowance. For further information please write supplying details of training & experience to Dr. J. P. Wells, M.O.H., Peterborough, Ont.

Supt. of Nurses immediately for 67-bed hospital. Salary open depending on training & experience. **Gen. Duty Nurses** also required. Good salary & personnel policies. New 80-bed hospital opening in 1956. Apply M. M. Barber, R.N., Administrator, Portage Hospital, Dist. No. 18, Portage la Prairie, Man.

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General Supervisors, Operating Room Nurses and General Duty Nurses for new 150-bed hospital. Starting salary for Registered General Duty Nurses $230 with annual increases to $40. 1½ days per mo. cumulative sick leave; 40-hr. wk; 28 days vacation; 10 statutory holidays. Apply: Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Operating Room Supervisor, Dietitian & Staff Nurses (2). Good salary & personnel policies. Apply Director of Nurses, General Hospital, Parry Sound, Ont.

Operating Room Supervisor for active surgical unit of 100-bed Ontario hospital .Approx. 1,800 cases annually. Vacation after 1 yr. service. Sick leave, statutory holidays & Blue Cross plan. Postgraduate diploma desirous but not necessary if experience is adequate. Apply Box No. 1, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25.

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Supt. of Nurses for modern 60-bed general hospital. Apply stating qualifications to Dr. M. R. Stalker, Hon. Medical Supt., Barrie Memorial Hospital, Ormstown, Que.

Obstetrical Clinical Instructor for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Instructor in Obstetrical Nursing. No administrative duties. 117 adults beds — 117 bassinets. 3-yr. school with an enrollment of 300 students. Instruction & clinical experience provided for neighboring university school of nursing. 44-hr. wk., paid statutory holidays, 1 mo. vacation. Cumulative sick leave, retirement plan & other attractive personnel policies. Minimum qualifications. 1 yr. postgraduate course in teaching & supervision & successful experience in obstetrical nursing required. Apply Director of Nursing, General Hospital, Hamilton, Ont.

Nursing Arts Instructor for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Instructor to teach anatomy and physiology, microbiology first term, followed by surgical nursing lectures and clinical supervision on surgical wards. Starting salary: $255; $10 for 2 yrs. experience; $10 yearly increments; 1½ days sick leave, cumulative; 10 statutory holidays; 40-hr. wk; 1 class per yr. in September. Apply to: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

UNIVERSITY HOSPITAL

SASKATOON, SASK.

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary $210.00 to $260.00 gross per month. Differential for evening and night duty.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASK.

Head Instructor for Training School to teach Sciences. 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec. Manager, General Hospital, Dauphin, Man.

Applications are invited for the position of Instructor for the School of Nursing in 138-bed Hospital. This school is affiliate with Montreal hospitals & with the teaching schools associated with McGill University. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Nursing Arts Instructor, Clinical Instructor — medical nursing, Head Nurses for General Hospital. Attractive personnel policies. Residence accommodation, if desired. New school unit. Apply Miss M. E Thompson, Supt. of Nurses, General Hospital, Regina, Sask.

Clinical Instructor in Pediatrics. Modern 450-bed Hospital. Maximum of 90 Students — 1 class a yr. Excellent personnel policies. Apply Director of Nursing Education, Kitchener-Waterloo Hospital, Kitchener, Ont.

Clinical Instructor in Obstetrical nursing for dept. with 26-beds & **Supervisor of Nurseries** for dept. with 30 bassinettes. Duties to include teaching & supervision of student nurses. University postgraduate course & experience preferred for both positions. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

Registered Nurses (2) for 50-bed hospital. Basic salary $180 per mo. plus maintenance, $5.00 increase every 6 mo. for 2 yrs. 44-hr. wk., 3-wk. vacation with pay after 12 mo. service. 10 statutory holidays. For further information apply Matron, Municipal Hospital, Wainwright, Alberta.

Registered nurse for specialty hospital in Detroit ($13 per day). **Several vanted** for large Chicago hospital ($12.96 per day). Send snap & write to International Employment Agency, 504 Victoria St., Windsor, Ont.

Registered Nurses (2) for 43-bed hospital. Gross salary: $210 per mo. $5.00 increment every 6 mo. to 2 yrs. Separate nurses' residence. For further information apply Matron, Municipal Hospital, Athabasca, Alberta.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONT.

Requires

CLINICAL INSTRUCTOR IN OPERATING ROOM

Gross salary commensurate with experience, 28 days vacation after one year, 8 statutory holidays, sick leave accumulative to 60 days; Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped and staffed wing with extensive renovation program progressing in the old section.

APPLY DIRECTOR OF NURSING

Registered Nurses for General Duty (2) for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross Salary: $205 per mo., perquisites $30, $5.00 increment every 6 mo., 1 mo. annual vacation with pay; 8-hr. day; 44-hr. wk. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

Registered Staff Nurses, immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Registered Nurses for General Duty. Initial salary: $200 per mo.; with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered Nurses for new modern 250-bed hospital located near the beautiful Beverly Hills area in sunny Los Angeles, Southern California's most glamorous city. Offers a new kind of opportunity for nurses interested in good patient care & learning about latest techniques. In a relaxed & beautiful atmosphere, work with friendly people, enjoy time off at nearby beaches & resorts. Housing facilities in the neighborhood. Starting salary: $300 per mo. with semi-annual increases for 3 yrs. Generous vacation. 8 paid holidays, sick leave, social security, group ins. & unemployment compensation. Opportunities for advancement. In-service program for R.N. & auxiliary workers. Apply Director of Nurses, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Registered General Duty Nurses (2) for 30-bed hospital. Salary: $170 per mo. plus full maintenance. Salary subject to increase after 6 mos. with regular annual increase thereafter. 30 days vacation after 1 yr. service. Fully modern nurses' residence. Successful applicants reimbursed rail fare after 1 yr. New 60-bed hospital under construction. Apply, stating age & when available to the Supt., Dist. General Hospital, Dryden, Ont.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered & Non-Registered Nurses, X-Ray & Lab. Technician for General Hospital. Gross salary for nurses registered in Ont. equivalent to $233.85 per mo. Good personnel policies, new facilities. 8-hr. rotating shifts; 44-hr. wk.; 1-day off 1 wk. & 2 the next. 1½ days holiday & sick leave per mo.; 8 legal holidays per year. Up to $40 travelling expenses & increase paid after 1 yr. service. Semi-private Blue Cross with M.O.S. coverage. Full maintenance is provided including room, board & laundering of uniforms. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

Registered Nurses (2) for 25-bed hospital. Salary: $210 per mo. Full maintenance $30. 1 mo. vacation & 3 wks., sick leave after 1 yr. service. Located in thriving town with good train & mail service. Apply Sec. Manager, Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

REGISTERED STAFF NURSES

Required by The Provincial Government of Newfoundland Department of Health

For General Duty in small 6-32-bed hospitals. Salary commences at $2,200 per annum on the scale $2,200-100-2,300.

Accommodation in the hospital $40 per mo. 24 working day vacation. Sick leave with pay. Uniforms & laundry services free. Successful applicants have their transportation paid to the hospital.

Hospitals situated in the coastal regions of the Province & act as the centre of Medical services for a group of settlements.

For further information & application form apply:

Director of Nurses, Dept. of Health, St. John's, Nfld.

Registered Nurses for newly opened 85-bed General Hospital located in northern portion of Los Angeles County. Basic salary: $280 with $10 per mo. differential for 3-11 & 11-7 shifts. 40-hr., 5-day wk. Positions available in all dept. Apply Director of Nurses, Antelope Valley Hospital, Lancaster, California.

Registered General Duty Nurse (1). Salary $180 per mo. with full maintenance & annual increases of $10 per mo. for 3 yrs. 3 wks. vacation after 1 yr. duty & 4 wks. annual vacation after 2 yrs. Apply Matron, District Hospital, Shoal Lake, Manitoba.

General Duty Nurses for large General Hospital in rapidly growing industrial city. Good working conditions, modern equipment. Generous personnel policies include paid vacation, sick leave & statutory holidays. Uniforms laundered. Residence facilities available at nominal charge. Apply Director of Nursing, General Hospital, Hamilton, Ont.

General Duty Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: $235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary $210 per mo. if registered in Ontario $200 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

General Duty Graduate Nurses for well equipped 72-bed hospital on B.C. coast. Salary: $222 per mo. less $25 full maintenance. Semi-annual increments. 28 days vacation plus 10 statutory holidays after 1 yr. Transportation advanced if desired. Apply Mrs. Mark, Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurses — We need nurses to assist in caring for our 147 tuberculous patients. If you wish to assist in the development of a good nursing program please write stating age, experience & salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal.

General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Graduate Nurse for 20-bed hospital. Salary: $190 plus full maintenance. Usual holidays with pay & sick leave. Modern nurses' home. Apply Union Hospital, Vanguard, Sask.

GENERAL STAFF NURSES

REQUIRED FOR ALL DEPARTMENTS

In new 300-bed general hospital to be opened soon

For further information apply to

DIRECTOR OF NURSING

SUDBURY MEMORIAL HOSPITAL

REGENT STREET SOUTH, SUDBURY, ONTARIO.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information, apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

Graduate Nurses for 100-bed West Coast General Hospital. Salary: $250 per mo. less $40 for board, residence, laundry. 3 annual increments; $10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to $60 refunded after 1 yr. Apply Director of Nursing General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, to Matron, Terrace & District Hospital, Terrace, British Columbia.

Operating Room & General Staff Nurses for 155-bed Acute General Hospital located in famed San Joaquin Valley. Starting salary: $285 per mo., $10 mo. additional for O.R., regularly scheduled increases. 40-hr., 5-day wk. paid vacation after 1 yr., 3 wks. after 5 yrs., 1 mo. after 10 yrs. Travel expenses refunded after 1 yr. employment. Apply Personnel Manager, Community Hospital, P.O. Box 1232, Fresno, California.

The Vancouver General Hospital invites inquiries from graduate nurses for general staff positions. Salary: $235.50 per mo. as minimum & $273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Apply Personnel Dept., General Hospital, Vancouver, B.C.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing. Salary: $288-$341. Shift, special service & educational differentials, $10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

Obstetrical Staff Nurses for General Hospital. Located in Central California. Night shift (12:00 midnight-8:00 a.m.). Excellent personnel policies. Nurses' residence. Apply Director of Nursing Service, Kings Co. General Hospital, Hanford, California.

UNIVERSITY HOSPITAL

Requires

ADMINISTRATIVE SUPERVISORS

to organize the departments of Pediatrics and Surgery in new hospital. Salary $240.00 to $300.00. Good personnel policies.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASK.

See Quebec With Employment Rather Than A Tourist Visit

GRADUATE NURSES FOR GENERAL DUTY

Where? **Jeffery Hale's Hospital**

Why Unique? **Only English speaking hospital & training school in Quebec City**

For information write:

DIRECTOR OR NURSES, JEFFERY HALE'S HOSPITAL, 54 ST. CYRILLE ST. EAST, QUEBEC, P.Q.

Maternity Nurses for modern 60-bed General Hospital located 40 mi. south of Montreal. Salary: $155 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Operating Room Nurses. immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Operating Room Nurses. preferably with experience, for 75-bed hospital. Operating unit consists of 2 theatres, emergency treatment & recovery room. Apply Supt., Carleton Memorial Hospital, Woodstock, N.B.

Acting Matron to relieve for 4 months during leave of absence of Matron, starting March 1, 1956. 60-bed hospital with 4 doctors. 2-room suite with bath available in residence. Personnel includes office staff of 3, x-ray & lab technician & housekeeper. Nursing staff consists of registered nurses, certified nursing aides & nursing aide trainees. State salary expected and give references. Position possibly permanent. For further information apply Matron, Municipal Hospital, Elk Point, Alberta.

Matron for 26-bed hospital. Salary according to experience. Accommodation provided. 28-days annual vacation. 1½ days sick leave per mo., cumulative. Apply Administrator, Terrace & District Hospital, Terrace, B.C.

REGISTERED NURSES

$2,430 - $3,120

ACCORDING TO QUALIFICATIONS

for

SUNNYBROOK HOSPITAL, TORONTO

and

WESTMINSTER HOSPITAL, LONDON

DEPARTMENT OF VETERANS' AFFAIRS HOSPITALS

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Office, should be forwarded to the Civil Service Commission, 25 St. Clair Ave., E., Toronto 7, Ontario.

GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

For full information please write

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION
48 SPARKS ST., OTTAWA 4, ONTARIO

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Director of Nursing & Nursing Education for 160-bed General Hospital. Postgraduate course in administration or equivalent experience required. Salary open. Applications should give details of education, qualifications & experience. Apply Administrator, The Victoria Public Hospital, Fredericton, N.B.

Registered Nurses for Charge Nurse & Supervisory position at Manitoba Sanatorium, Ninette, Man. Extensive chest surgery provides interesting work & worthwhile experience. Salary range: $220-$265 per mo. depending on qualifications & appointment. Board, room & laundry provided for $45 per mo. Comfortable quarters in new nurses' residence. Generous vacation, all statutory holidays, group ins. & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Pediatric Head Nurse (1), Operating Room Nurse (1) preferably with experience, **General Duty Nurses** for rotating shifts for 140-bed small teaching hospital. Apply Director of Nursing, General Hospital, Brandon, Manitoba.

General Duty Nurses for 65-bed hospital. Gross salary: $185-$210. 44-hr. wk., statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

Dietitian for 65-bed hospital. Good working conditions. Living accommodation available. For further information apply Administrator, General & Marine Hospital, Collingwood, Ont.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

OPERATING ROOM SUPERVISOR

Applications are being received for

Operating Room Supervisor for February 1956.

Postgraduate course & experience required.

Good personnel policies & salary.

For further information, write

DIRECTOR OF NURSING, VICTORIA HOSPITAL, LONDON.

Public Health Nurses for the City of Vancouver. Qualifications: Candidates must be eligible for registration in B.C. & must possess either a University degree or certificate in Public Health Nursing. Salary: $269-321 per mo., benefit plans in effect. Application forms must be obtained from & returned to the Personnel Director, City Hall, 453 W. 12 Ave., Vancouver, B.C.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: $288-337 per mo. 40-hr. wk., liberal vacation, holiday & sick leave plans. Apply Personnel Office, 510 E. Market St., Stockton, California.

General Duty Nurses. O.R. Scrub Nurse, O.B. Supervisor for new 143-bed plus 32-bassinette hospital. Good salary & personnel policies. Apply Director of Nurses, Plummer Memorial Hospital, Sault Ste. Marie, Ontario.

Graduate Nurses for 22-bed Memorial Hospital in Nipigon District. Duties to commence Jan. 1, 1956. Accommodations in hospital. Apply Mrs. C. F. McInnis, Sec., Hospital Board, Box 457, 309 Churchill St., Nipigon, Ont.

Registered Nurses for general duty in busy 60-bed hospital in Eastern Ontario. 3-wk. vacation after 1 yr., 2-wk. sick leave, all statutory holidays. Apply Supt., Public Hospital, Smiths Falls, Ontario.

Office Nurse with commercial training required for doctor's office January 1956. Must have ability to take full responsibility for running large office practice in St. Catharines. Apply Box J, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Director, School of Nursing with duties as Asst. Director of Nursing Service for accredited completely new 117-bed & 22-bassinet General Hospital situated in a very beautiful part of western New York State approx. half way between Buffalo & Rochester. This is a county-community hospital & is somewhat unique in that med. services are administered through full-time board certified physicians. Of particular interest is the community centered hospital with its Nursing School, Medical Services & full-time County Health Dept. all in the same building. Possible applicants require a degree in nursing education or equivalency, as well as 5 years' experience in nursing school administration or teaching. We have been successful in obtaining a waiver of U.S. citizenship, but a declaration of intention of becoming a U.S. citizen (1st papers) is required. Salary: $4,800-$5,400 plus maintenance. 5-day wk., 4-wk. paid vacation per annum. Blue Cross & Blue Shield ins. available. Excellent working conditions. The position is under Civil Service & the New York pension plan. Apply Supt., Wyoming County Community Hospital, Warsaw, N.Y.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant town. Within 50 mi. of Toronto & several resorts. Salary: $200 per mo. gross. 44-hr. wk., 8-hr. day, 2 wk. shift rotation. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate Nurses at once. 20 mi. east of Toronto. Salary $225 per mo. Single room residence. Apply Supt., Ajax & Pickering General Hospital, Ajax, Ontario.

General Duty Nurse for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: $240, full maintenance, $40. 44-hr. wk. vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary, refunded following 1 yr. service. References required. Apply Bulkley Valley Dist. Hospital, Smithers, B.C.

Opportunities for full time Staff Nurses interested in the field of rehabilitation at Benjamin Rose Hospital. Starting salary: $249 per mo. 8-hr. day, 40-hr. wk., 3 wks. vacation, 6 paid holidays. A new hospital affiliated with Western Reserve University Medical School. Apply Director, 2073 Abington Rd., Cleveland 6, Ohio.

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec Incorporated February 14, 1920.

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Belleville General Hospital

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School of Nursing, University of Toronto

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